



DOCTOR OF CLINICAL PSYCHOLOGY (DCLINPSY)

Doctorate in Clinical Psychology: Main Research Portfolio

1) Is indiscriminate friendliness a symptom of disordered attachment in institutionalised children? A review of the literature; evaluation of a group for caregivers; experimental investigation into young people's ability to use metaphors within therapy.

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Doctorate in Clinical Psychology:

Main Research Portfolio

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May 2014

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Word Count

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Abstracts

Critical Literature Review

Indiscriminate friendliness (IF) is a concept that is poorly understood within the field of institutionalised and maltreated children. Theories as to its existence vary from IF being a disorder of attachment, to neurobiological theories proposing IF to arise out of the interaction between a severely deprived upbringing and genetically predisposed brain abnormalities. The current literature review aims to look at studies that have investigated the interaction between attachment and indiscriminate friendliness, in order to ascertain whether IF is, in fact, a symptom of disordered attachment. Findings were considered in relation to quality of studies and literature within this field.

Using specific search criteria, 11 papers were found and evaluated. Findings concluded that IF was not a symptom of disordered attachment, due to the majority of papers failing to find a link between the two constructs. Studies were evaluated in terms of sampling, measurement, analyses, and design.

The review pulls together the literature on indiscriminate friendliness, which has previously been confined to the area of attachment. The review highlights potential areas for exploration such as the background of families, as well as the assessment of quality of care, and how this impacts on the development of IF. The review also raises concerns around the measurement of this construct, and calls for further use of validated measures.

Service Improvement Project

This study describes the development of a new group using psychological approaches for caregivers of individuals with dementia. This follows consultation with the service and its users, to the implementation and running of this group. Thematic analysis was used to extract key themes on the utility of the group. Barriers to intervention have been identified, and further research recommendations have been made.

Main Research Project

Background: Metaphors are commonly used within clinical settings to communicate concepts to young people. Whilst theories of how metaphors work have been proposed, alongside ideas to implement metaphors effectively, there has been little research as to whether metaphors impact upon memory and understanding, in comparison to basic language. **Aims:** The current study aims to assess whether metaphorical explanations leads to improved memory and understanding for psychological concepts.

Method: 25 participants took part in the study (10 boys and 15 girls). Individuals who were on the waiting list for Cognitive Behaviour Therapy (CBT) were given the opportunity to watch a video which explained the main concepts of CBT. Half of the participants watched a video with metaphorical explanations (Metaphor group); the other half watched a video using basic language (Psychoeducation group). The participants answered questions immediately after the video and then four weeks later, on psychopathology, memory and understanding measures. **Results:** T-tests were carried out to determine any differences between the two groups. There were no significant differences on all variables tested (memory, understanding, intention to change) immediately or after four weeks. Correlational data, looking at the link between age and understanding/memory between the two groups found that older individuals were more likely to understand and remember the content of the Psychoeducation video. Whilst this correlation did not differ significantly from the Metaphors group, there were no such trends for individuals exposed to a metaphorical understanding. **Conclusions:** Metaphors do not appear to enhance memory and understanding of young people, in comparison to basic language. However, it seems they are equally understood by younger and older children, therefore making them an accessible way of communicating complicated concepts. Definitive conclusions cannot be made due to the small sample size, so there is a call for further research in this area.

Critical Literature Review

Is indiscriminate friendliness a symptom
of disordered attachment in
institutionalised children? A review of
the literature.

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Under supervision of Dr. Ailsa Russell

January 2014

I aim to submit this paper to Clinical Psychology Review. This is because it publishes reviews on a range of different topics relevant to psychology. Previous reviews in this area have also been published in this journal.

Abstract

Indiscriminate friendliness (IF) is a concept that is poorly understood within the field of institutionalised and maltreated children. Theories as to its existence vary from IF being a disorder of attachment, to neurobiological theories proposing IF to arise out of the interaction between a severely deprived upbringing and genetically predisposed brain abnormalities. The current literature review aims to look at studies that have investigated the interaction between attachment and indiscriminate friendliness, in order to ascertain whether IF is, in fact, a symptom of disordered attachment. Findings were considered in relation to quality of studies and literature within this field.

Using specific search criteria, 11 papers were found and evaluated. Findings concluded that IF may not be a symptom of disordered attachment, due to the majority of papers failing to find a link between the two constructs. Studies were evaluated in terms of sampling, measurement, analyses, and design.

The review pulls together the literature on indiscriminate friendliness, highlighting potential areas for exploration such as the background of families, as well as the assessment of quality of care, and how this impacts on the development of IF. The review also raises concerns around the measurement of this construct, and calls for further use of validated measures.

Introduction

Indiscriminately friendly behaviour or disinhibited social behaviour is commonly seen in children brought up in institutional settings (C. K. Chisholm, 1997; O'Connor, 2003; M. L. Rutter, Kreppner, & O'Connor, 2001; Tizard, 1977). This disinhibition is characterised by affectionate behaviour towards all individuals, including strangers, and a distinct lack of fear or caution towards unknown individuals (Bakermans-Kranenburg et al., 2011). A seemingly pleasant characteristic initially, with children able to engage and relate to a range of individuals, indiscriminate friendliness can actually demonstrate and fuel a problematic relationship with caregivers, as well as contribute to longer term difficulties.

The longest follow-up study of institutionalised children was carried out in the UK of children living in residential nurseries (Hodges & Tizard, 1989). Rates of indiscriminate friendliness were markedly higher in those that lived in institutional settings for longer. These children were followed up until the age of 16 years. Throughout this time it was clear that the only variable that distinguished previously institutionalised children from those that were never institutionalised, was the presence of indiscriminate friendliness. At the age of 16 years, indiscriminate friendliness had diminished, but the long term implications were seen of this construct. Significant peer relationship difficulties were evident, and suggested an “ex-institutional syndrome” (Zeanah, Smyke, & Dumitrescu, 2002). It has been hypothesised that indiscriminate friendliness is the pre-cursor to this difficulty, therefore emphasising its crucial role in the post-institutional phase.

This characteristic has baffled researchers and clinicians over the years, as the aetiology and the mechanisms behind indiscriminate friendliness (IF) are still contested. IF has been considered by some as a subtype of reactive attachment disorder (RAD) (O'Connor et al., 2000) which is classified in ICD 10 and DSM IV-R. Others consider IF as an independent problem (K. Chisholm, 1998; Zeanah, 2000) that is not linked with attachment security, but this is an area that has been discussed around the nosology of Reactive Attachment Disorder and the development of DSM V.

Reactive attachment disorders are defined in terms of “markedly disturbed and developmentally inappropriate social relatedness in most social contexts that begins before the age of 5 years, and that is persistent over time, and which is not purely a consequence of either social anxiety, an autistic spectrum disorder or intellectual disability” (M. Rutter, Kreppner, & Sonuga-Barke, 2009). DSM IV splits up the diagnosis into an ‘inhibited’ subtype and ‘disinhibited’ subtype, with ICD 10 classifying ‘inhibited’ and ‘disinhibited’ attachment as separate constructs. Research into the two attachment disorders have identified them as both being very different to

each other (Zeanah et al., 2006) supporting the distinction between these two concepts.

It must be noted that the characteristic of indiscriminate friendliness is not just seen in children with an institutional background. Children that have been maltreated also present with similar characteristics of indiscriminate friendliness (Pears, Bruce, Fisher, & Kim, 2010). However, it is seen that the function is perhaps different in this population (Bakermans-Kranenburg, et al., 2011). Children reared in a dysfunctional home environment, being exposed to maltreatment, may have formed attachments that are distorted or disturbed. In the case of institutionalised children there is often no attachment that has been formed, and therefore the function and aetiology of the indiscriminate friendliness may be different.

Theories of Indiscriminate Friendliness

As IF is observed in children with little opportunity to develop secure attachment relationships, a key theory of IF aetiology is that it is a symptom of disordered attachment. If a child does not develop a secure attachment to one caregiver, it may make sense that this child is indiscriminately friendly to others (including strangers) in an attempt to receive optimal care.

IF has also been proposed to have an adaptive function for children whilst living in an institution (K. Chisholm, 1998). Children that are friendly and do not show a specific sensitivity for one or two selective caregivers, are more likely to be popular and potentially adopted quicker. The question remains as to why children maintain indiscriminately friendly behaviour once they have been adopted and left the institution. Chisholm (1998) discusses the possibility of reinforcement playing a role, as IF was not seen to be a problem in the majority of adoptive caregivers that she interviewed.

Another theory explaining this is proposed by Michael Rutter (2007a) who has conducted research with institutionalised children. He states that there

may be a biological disturbance within institutionalised children at a critical period of development that may have an effect on brain structure and functioning.

Recent research uses knowledge about Williams Syndrome to understand the causes of indiscriminate behaviour in institutionalised children, as this is a characteristic often seen in individuals with this genetic disorder (Soares, Belsky, Mesquita, Osório, & Sampaio, 2013). A model has been proposed focusing on the interactions between genetic predispositions (polymorphism variations within the Williams syndrome critical region of the brain), and a deprived environmental upbringing, to explain the onset of indiscriminate friendliness in some children brought up in institutions. This theory has the advantage of explaining why perhaps not all children brought up in institutional settings develop this characteristic. Evidence to this effect has been found in the Bucharest Early Intervention Project (BEIP), that looked at previously institutionalised children and the role of genetics in determining indiscriminate friendliness (Drury et al., 2012).

Measurement of IF

Measurement of disinhibited attachment or indiscriminate friendliness has relied on interviews with caregivers, such as The Disturbances of Attachment Interview (Smyke & Zeanah, 1999) and the 5IF (Chisolm 1998). Convergence among these interviews has been demonstrated (Zeanah, et al., 2002), but interviews are generally considered less valid than direct observations of behaviour (Bakermans-Kranenburg, et al., 2011). Indiscriminate friendliness has been noted during observational assessments of attachment, such as the Strange Situation Procedure (SSP) (Ainsworth, Blehar, Waters, & Wall, 1978) and the Attachment Q Sort (AQS) (Waters & Deane, 1985) even though these assessments are not designed to measure IF. Specific observational assessments of IF are rare, but Bruce et al. (2009) developed an assessment looking at children aged 6-7 years old, where interactions with a stranger were coded, alongside a semi-structured interview. During the Bucharest Early Intervention Program, an observational assessment of indiscriminate friendliness was developed, called the Stranger in the Door Procedure

(Zeanah, Smyke, & Dumitrescu, 2005) utilising a task where a stranger comes to the door and asks the child to go with them. An adapted Strange Situation Procedure (SSP) has also been developed, to look at indiscriminate friendliness in more detail in younger children. The Rating of Infant and Stranger Engagement (RISE) (Riley, Atlas-Corbett, & Lyons-Ruth, 2005) uses the main observational tasks of the SSP and builds on this with additional coding.

Literature to date has supported the existence of a concept in line with an indiscriminately friendly presentation. However, the aetiology and the measurement of this concept are still under evaluation. This literature review serves to answer the question of whether indiscriminate friendliness is a symptom of disordered attachment, by assessing studies that have looked discretely at both of these constructs. Studies that have identified a link between these two constructs, will be used to conclude whether IF is linked to attachment. The literature in this field will also be evaluated, outlining threats to validity and inconsistencies in approach and measurement. A more coherent understanding of the concept of indiscriminate friendliness in relation to attachment will broaden understanding in the field, ultimately contributing to information about the aetiology of IF and possible early interventions.

Definition of terms

The key terms that are used in the review are: 1) Indiscriminate friendliness and 2) disordered attachment.

Indiscriminate friendliness is a term that has been used in addition to other terms such as “indiscriminate behaviour” and “disinhibited attachment”.

Disinhibited attachment has been described as an umbrella term under which indiscriminate friendliness falls. It refers to the idea that attachments are not selective, and can be formed easily with strangers.

More specifically disinhibited attachment has been defined “in terms of a lack of close confiding relationships, somewhat indiscriminate friendliness,

a relative lack of differentiation in the response to different adults, a tendency readily to go off with strangers, and a lack of checking back with a parent in anxiety-provoking situations.” (M. Rutter et al., 2007b).

“Indiscriminate behaviour” is a term that refers to a “pattern in which attachment behaviours are evident but are directed non-selectively or indiscriminately, even at relative or complete strangers” (Zeanah, et al., 2002).

“Indiscriminate friendliness” is more specific in its definition, as it refers to the friendly disposition that is encompassed within “indiscriminate behaviour” and “disinhibited attachment”.

Based on the definitions in the literature, disinhibited attachment is a slightly boarder term which encompasses an indiscriminately friendly presentation but also refers to the lack of close and confiding relationships. Indiscriminate behaviour and indiscriminate friendliness are phenomenologically and conceptually the same, with elements of disinhibited attachment mapping onto the same conceptual category. Thus “indiscriminate friendliness” will be used as a key term, and both “disinhibited attachment” and “indiscriminate behaviour” will be subsumed within this.

For the purpose of the review, ‘disordered attachment’ has been used to question the idea that indiscriminate friendliness has a direct link to the attachment disturbances seen in this population. ‘Disordered attachment’ is not another term for Reactive Attachment Disorder (RAD).

Methodology

Inclusion Criteria

The inclusion criteria for this review were:

- a) The sample were either currently or previously institutionalised children;
- b) Attachment and indiscriminate friendliness were measured as separate constructs and outlined in the methodology;

c) Analyses had been conducted looking at the link between attachment and indiscriminate friendliness.

Both cross-sectional and longitudinal studies were included in the review, as the literature has stated that attachment can change following placement with a family, therefore it is valid to include longitudinal data. Longitudinal studies were often repeat cross-sectional studies. The initial or 1st study findings were treated as cross-sectional in nature and included in the review as findings addressing the main research question. Findings from repeat measurement, or from longitudinal studies, will be presented separately to represent stability across the relationship between IF and attachment style.

Quality assessment

No studies were excluded due to quality criteria. This is because the attachment and IF measurement methodology varies greatly, and the review wanted to maximise the pool of studies that could be included. However, care was taken over which construct was assessed by which measure. For example, the Disturbances of Attachment Interview (DAI) counted as a measure of indiscriminate friendliness, rather than a measure of attachment, as it looked at the inhibited and disinhibited subtypes of reactive attachment disorder.

Search Strategy

The papers included in this review were identified using the databases PsychInfo, PubMed and Scopus. Search phrases used were: (“indiscriminate friendliness” OR “indiscriminate behaviour” OR “disinhibited attachment”) AND institutional*. The search terms were looked for in “All fields” so as to include studies that may have recognised IF in their study without mentioning it in the title/keyword. 361 papers were found using this method.

In addition, references of included papers were screened for eligible studies, as well as references of review articles in this area. Authors of papers in this field were also contacted to see whether the latest research

and unpublished papers could be included in the current review. Three extra papers were found using these methods.

All papers found from the databases and the external sources were collated and duplicates removed.

Study selection

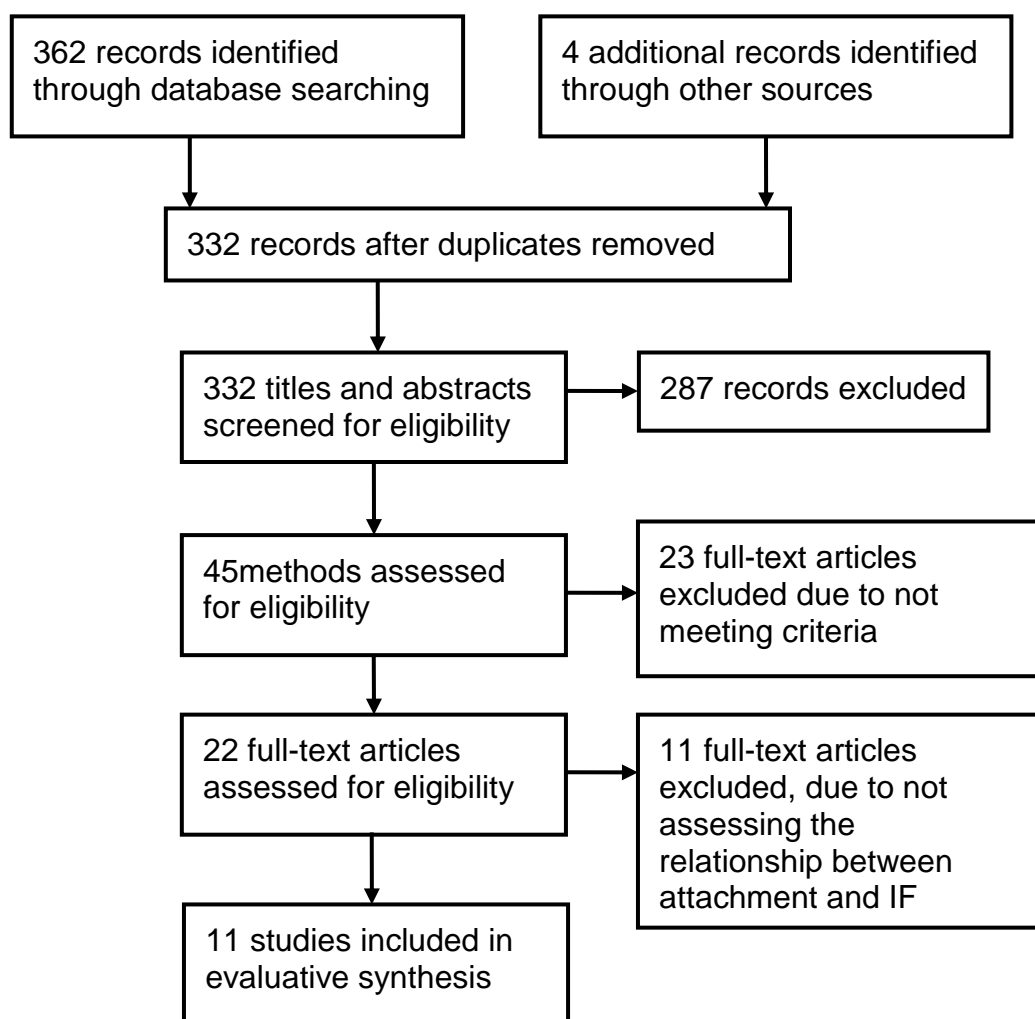
The process of study selection can be seen in Figure 1 below. Following the exclusion of duplicates, there were 332 papers found in total. Each title and abstract was then screened for the inclusion criteria outlined above. Papers were excluded that did not have institutionalised children as a population group, and those that did not address the concept of indiscriminate friendliness or disinhibited attachment in the abstract. Peer-reviewed papers formed a bulk of the review, but theses and book chapters were also assessed for eligibility.

Following exclusions, 45 papers were found to meet the inclusion criteria. In order to assess indiscriminate friendliness and attachment in detail it was decided that the methods sections of these papers would be screened at this point, to see whether attachment and indiscriminate friendliness were measured in the studies. Both observational measures and interview measures were accepted as appropriate methods of assessment, as long as there was a resulting classification of the constructs. Un-validated measures of attachment and indiscriminate friendliness were also included, due to the limited amount of validated measures in the field of IF.

After assessing the methods section on each of the 45 papers, 23 were excluded due to not measuring both attachment and indiscriminate friendliness separately. Twenty two full text articles were then reviewed, with 11 being excluded due to not assessing the relationship between attachment and indiscriminate friendliness, which was a key role of the current review.

The final 11 articles are evaluated in turn, with conclusions and recommendations being drawn at the end. This process has been outlined in Figure 1.

Figure 1: The literature search process



Data extraction and synthesis

Data was extracted from the 11 papers and placed into tables, outlining: the sample size, ethnicity and age; measurement of IF and attachment; and conclusions relating to the target review question. A more narrative synthesis of data was collected, relating to the study design, key findings, as well as study quality.

Due to the heterogeneity of studies included in the review with regards to sample age, ethnicity and measurement of target constructs, a meta-analysis, or more rigorous statistical analyses, was not able to be conducted.

It must be noted that some of these studies have been recruited from the same pool of participants. For example, one of the studies generates follow up data from another study included in the review. This data was included in the review with the follow up data addressing stability of constructs over time. Three studies were also recruited from the Bucharest Early Intervention Project (BEIP), in which a large number of children were placed into foster care from Romania. It was considered important to place all of these studies into the review as they all have different aims, use different combinations of participants and have run different analyses.

Results

Out of the 11 studies reviewed, approximately half use a cross sectional design, with the rest using a longitudinal design for their study. 10 out of the 11 studies had a comparison group.

Approximately 8 of the studies were recruited from a predominately Romanian sample, with the rest looking at institutionalised children from countries such as the Ukraine, and China.

Only one study did not use a control group. Whilst the nature of these control groups varied (i.e. some were children that were fostered and

adopted, and others were children still living with their biological parents), all of the control groups had never been institutionalised.

Seven out of the 11 studies assessed cognitive ability within the sample using a standardised measure. It was considered important to assess for this variable, as it has been seen that individuals with a learning disability are more likely to present with indiscriminately friendly behaviour. Four out of the 11 studies measured condition of institution or quality of caregiving environment, often using caregiver report.

The sample characteristics and methodology of the studies can be seen in Table 1a below. In adjoining Table 1b there is an outline of the measures used, and the conclusions derived in relation to the review question. Statistics were reported in most studies, but three studies included in the review did not report specific statistics when there was not a significant effect.

For the remainder of the review, the studies will be referred to by the Study ID number that has been assigned to them in Tables 1a and 1b.

Table 1a: Sample characteristics and methodology of studies

<i>Study ID</i>	<i>Author</i>	<i>Title</i>	<i>Sample</i>	<i>Ethnicity</i>	<i>Age of sample</i>	<i>Gender of sample</i>	<i>Study design</i>	<i>Currently institutionalised/post adoption</i>	<i>Control group present?</i>
1	(Bruce, et al., 2009)	Disinhibited social behaviour among internationally adopted children.	120 children	Eastern Europe (45%) and China (43%)	6-7 year olds	30 girls 10 boys	Cross-sectional	17.73 months in institution 18.58 months when adopted	Foster care and non-adopted
2	(Kim Chisholm, Carter, Ames, & Morison, 1995)	Attachment security and indiscriminately friendly behaviour in children adopted from Romanian orphanages.	46 children	Romanian	30 months (17-76 months range)	26 girls 20 boys	Cross-sectional	8-56 months in orphanage 18.5 months median age at adoption	Romanian born, Canadian adopted Canadian born
3	(K. Chisholm, 1998)	A 3-year follow-up of Attachment and Indiscriminate Friendliness in Children Adopted from Romanian Orphanages	46 children	Romanian	54.5 months (50-110 months range)	21 males 25 females	Longitudinal	As above	As above

4	(Dobrova-Krol, Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2010)	The importance of quality of care: Effects of perinatal HIV infection and early institutional rearing on pre-schoolers attachment and indiscriminate friendliness.	29 children	Ukraine	50 months average	Not specified for institutional-ised group	Cross-sectional	47 months on average in institution	Family reared children
5	(McGoron et al., 2012)	Recovering from early deprivation: Attachment mediates effects of caregiving on psychopathology.	126 children	Slightly more than half Romanian, others unknown	At baseline – mean age 22 months	Slightly more than half female	Longitudinal BEIP	All lived in institution for at least 22 months	Foster care and adopted children were compared to institutional-ised children
6	(Olsavsky et al., 2013)	Indiscriminate amygdala response to mothers and strangers after early maternal deprivation	33 previously institutional-ised children	Not reported	6-15 years old	Not reported	Cross sectional	Currently adopted	Comparison group (34) living with biological parents

7	(M. Rutter, et al., 2007a)	Early adolescent outcomes for institutionally deprived and non-deprived adoptees. I: disinhibited attachment.	165 children	Romanian	6 years	91 girls 74 boys	Longitudinal	58 adopted before 6 months 59 adopted between 6-24 months 48 adopted between 24-42 months	52 UK born children – adopted before 6 months
8	(Van Den Dries, Juffer, Van IJzendoorn, Bakermans-Kranenburg, & Alink, 2012)	Infants' responsiveness, attachment, and indiscriminate friendliness after international adoption from institutions or foster care in China: application of Emotional Availability Scales to adoptive families	50 post-institutionalised children	Chinese	13.03 months	All girls	Short term longitudinal	Adopted – aged 11-16 months on arrival	42 formerly fostered girls

9	(Zeanah, et al., 2002)	Attachment Disturbances in Young Children. II: Indiscriminate Behaviour and Institutional Care	61 children	Romanian	11-70 months	35 boys 26 girls	Cross-sectional	Currently institutionalised	No
10	(Zeanah et al., 2005)	Attachment in institutionalized and community children in Romania	95 children	53.5% Romanian 32.3% gypsy Roma 14.1% unknown/other	23.85 months 12-31 months range	43 female 52 male	Cross-sectional BEIP	Currently institutionalised	50 never institutionalised Romanian children
11	(Gleason et al., In press)	Indiscriminate behaviours in young children with a history of institutional care	60 children (31 care as usual, 29 foster care group)	Romanian	17.3 months for foster group 16 months for care as usual	33 girls 27 boys	Cross sectional within longitudinal study BEIP	84% of life in institution	29 never institutionalised

Table 1b: Outline of the measures used, and the conclusions derived in relation to the review question

<i>Study ID</i>	<i>Author</i>	<i>Attachment measurement</i>	<i>IF measurement</i>	<i>Conditions of orphanage reported</i>	<i>Intelligence of child reported</i>	<i>Cross-sectional findings in relation to the question</i>	<i>Significant findings about stability from longitudinal studies</i>	<i>Conclusions - Is IF related to attachment?</i>
1	(Bruce, et al., 2009)	Semi-structured interview	Observational measure from Tizard (1977) Semi-structured interview	No	Yes – Weschler Intelligence Scale for Children 1 individual below average IQ.	No significant correlation ($r(118) = -.05, n.s$)		No
2	(Kim Chisholm, et al., 1995)	Attachment Q Sort	5 questions	No	No	No significant correlation for both groups (Romanian orphanage group [$r(33) = -.10, n.s$] or the Early adopted group from orphanage group [$r(29) = -.25, n.s$])		No

3	(K. Chisholm, 1998)	Parent interview of Attachment Q Sort (AQS) Separation-reunion procedure observation coded using Pre-school Assessment of Attachment (PAA).	Parent interview (5IF) Parent interview (2IF)	Yes - 3 questions asked	Stanford-Binet Intelligence Test carried out	Negative associations between IF scores and attachment scores on both the 5IF ($r(46) = -.40$, $p < .01$) and 2IF ($r(46) = -.54$, $p < .01$) No difference between secure and insecure on 5IF. Difference between secure and insecure on 2IF ($t(41) = 2.01$, $p < .05$).	Children adopted early from Romanian orphanage scored lower on IF at Time 2 (3 years later) ($M = .76$) than they had scored at Time 1 ($M = 1.6$), ($t(24) = 3.80$, $p < .001$).	Yes
4	(Dobrova-Krol, et al., 2010)	Strange Situation Procedure (SSP) (coded using Cassidy & Marvin)	Semi-structured interview (same as Chisholm, 1998 – took out item 1)	No	Snijders–Oomen Nonverbal Intelligence Test (SON-R) carried out	Including attachment security did not explain any more variance on IF regression (no statistics reported)		No

5	(McGoron , et al., 2012)	SSP	Disturbances of Attachment Interview (disinhibited subtest)	No	No	Indiscriminate social/disinhibited RAD correlates with attachment security ($r = -0.40$, $p < 0.01$)		Yes
6	(Olsavsky , et al., 2013)	Security Scale, self-report	Questionnaire – 3 questions	No	Weschler Abbreviated Scale of Intelligence	No correlation between attachment and IF (no statistic reported) Imaging suggests response to stranger stimuli rather than mother stimuli		No
7	(M. Rutter, et al., 2007a)	Modified SSP	Semi-structured interview (3 questions rated score of 0-2)	Yes – asked parents to rate condition of institution (between 0-3). Conditions varied between poor and abysmal	Weschler Intelligence Scale for Children	'Mild and marked disinhibited' groups differed to 'no disinhibition' group on security of attachment - there were more 'insecure other' and less 'secure' ($\chi^2 = 8.28$, d.f. = 2, $p < .05$)		Yes

8	(Van Den Dries, et al., 2012)	SSP	5IF	No measure of condition of institution – but mention of the progressive nature of Chinese institutions	No		No relation between IF and other variables between Time 1 and Time 2 ($r = -.01, .18, -.14, -.09$, n.s. for respective variables). No correlation between IF and attachment security at T1 and T2.	No
9	(Zeanah, et al., 2002)	Semi-structured interview	Semi-structured interview	No	No	Having a preferred caregiver did not protect against IF (no statistics provided).		No

10	(Zeanah, Smyke, Koga, et al., 2005)	SSP – assessed with favourite caregivers	Disturbances of Attachment Interview	Assessed the 'quality of caregiving' using The Observational Record of Caregiving Environment	Bayley Scales of Infant Development II	Attachment unrelated to ratings of indiscriminate behaviour ($r = -.16$, $p = .07$)		No
11	(Gleason, et al., In press)	SSP	Stranger at the door	Assessed the 'quality of caregiving' using The Observational Record of Caregiving Environment	Wechsler Preschool Primary Scale of Intelligence (WPPSI-R)	Attachment disorganisation predicted leaving with the stranger on the IF measurement (odds ratio $ExpB$ of 1.6, $p < 0.05$)		Yes

Is Indiscriminate Friendliness related to attachment?

All findings from studies 1-11 have been outlined in Table 1b. Eight out of the 11 studies used correlational analyses to ascertain whether there was a link between the two constructs. Other studies used regressions to see what factors predicted IF, and Chi Square if the data was non-parametric. Significant links between attachment and IF were found in four out of the 11 studies. Therefore seven studies found that there was not a significant link between the two constructs (for specific statistics see Table 1b). The studies must be evaluated effectively in order for this review to be considered valid.

Study Quality

Sample

Sample sizes varied throughout the studies, and a potential source of bias is the power for the studies to be able to yield significant results. None of the studies reported power sizes, which is problematic. However, for a medium effect size of 0.5 and power of 0.8, the study requires a minimum sample of 25 for a correlational analysis. Based on this, none of the studies in the literature review are under-powered.

The majority of studies in the review had Romanian children as their sample. This provides a cultural bias in the review, as it is not clear whether the results yielded are specific to the cultural nuances and paradigms within a country. Other confounding variables may be the variance of the orphanage conditions, which differs from country to country.

Cognitive ability was assessed within the majority of studies included in the review. Unfortunately, only study 1 described how many children fell below the average range for IQ, and no studies reported whether there were any participants with a learning disability, or whether individuals had been screened out of the study due to having a learning disability. Whilst this may have had an impact on the characteristics of children included in the studies, it could also tell us a lot about the nature of indiscriminate

friendliness, as we know that individuals with a learning disability have a higher vulnerability to this trait.

Measures of IF

When measuring indiscriminate friendliness, ten studies used semi-structured interviews, with study 1 coupling this up with an observational measure. Out of these ten studies, two used the Disturbances of Attachment Interview and three based their interviews on Chisholm's five questions used in her 1995 and 1998 study. Study 4 found that Chisholm's 5IF had much higher convergence value when the first item was taken out.

Observational measures of IF varied, with only one study using the newly developed Stranger in the Door procedure (study 11) and another using an unvalidated observational measure (study 1). None of the studies included in this review used the RISE or a modified version of the SSP to assess indiscriminate friendliness.

This review highlights significant variance in the measurement of IF. Further studies in this area would be beneficial, focusing on the utilisation of validated assessment measures as well as a combination of both observational methods and semi-structured interviews.

Measures of attachment

Nine out of the 11 studies used a validated observational measure when looking at attachment, such as the SSP, with the other 3 using semi-structured interviews. Due to the age variance of children presented in each of the studies, the SSP had to be modified in some of the studies. Descriptions of modified SSPs were lacking, however. For example in study 7, it would be useful to know how the SSP was modified for 6-7 year olds, to allow other studies to be able to replicate this methodology.

Semi-structured interviews are not a valid way of assessing attachment security quantitatively. However, these studies were more interested in the qualitative nature of the attachment behaviours that were being displayed,

and the level of comfort a child is able to seek. This, however, leaves studies 1, 6 and 9 vulnerable to validity issues.

Analyses

The majority of studies used correlational analyses to ascertain whether there was a link between attachment and indiscriminate friendliness. This analysis is problematic as it does not specify causality.

Findings from longitudinal studies

Studies with a longitudinal design allowed researchers to consider the stability of the constructs. Key findings established that children adopted early from institutions scored lower on indiscriminately friendly behaviour three years later than the first study. Just over half of the studies included in the review have used a cross sectional design. As this is a static view of functioning, measures may not have reliably captured attachment styles or indiscriminate friendliness ratings over time.

Discussion

Indiscriminate friendliness is a concept seen in institutionalised children that is not well understood. In order to advance understanding about the aetiology of this concept, the literature looking at the link between attachment and indiscriminate friendliness was reviewed. The majority of studies did not find a link between the two constructs, which led to the conclusion that indiscriminate friendliness may not be a symptom of disordered attachment.

So, if it has been found that IF may not be a symptom of disordered attachment, then what is it? Much research has been done on factors that predict indiscriminate friendliness, such as quality of care (Dobrova-Krol, et al., 2010) and the background of families (Oliveira et al., 2012). Both of these emphasise the importance of the environment and contextual upbringing of the young person.

The studies that were included in the review were a direct measurement of the child, and most did not take into account the context and institutional conditions a child came from, as well as the nature of caregivers that the child had exposure to. In some severely deprived institutions there has been evidence of high levels of abuse and consequently trauma responses within the children. Trauma measures were not carried out in any of the studies looking at IF, which could be a key predictor of this construct.

The results in this review need to be discussed within the context of the review's limitations, along with the studies that are included within it.

Ages of participants varied dramatically in the review with the youngest participants being 11 months old and the oldest being 15 years old. The heterogeneity of these studies raises questions as to the validity of the review. Longitudinal studies specifically assessed whether the quality of IF is different over time, but it may have been of interest to monitor the responses of caregivers and individuals to these indiscriminately friendly children. Overly friendly behaviour may have been more acceptable to see in younger children, and this may therefore play a role in terms of reinforcing the behaviour.

Study 9 carried out semi-structured interviews to ascertain attachment with favourite caregivers within the institution. It is questionable as to whether the construct of attachment which is being assessed with a favourite caregiver, is the same as the type of attachment assessed in the other studies. Further research has found that individuals with a preferred caregiver were reported to present with significantly more indiscriminately friendly behaviour, to those with an adopted parent. This therefore raises validity issues within the review.

It is hard to draw conclusions about the direction of the causal relationship, if any, between indiscriminate friendliness and disordered attachment. Many of the studies have been correlational and thus it is not clear whether indiscriminate friendliness arises as a result of attachment

difficulties or whether indiscriminate friendliness may precede or bring about difficulties in attachment.

This review points to further exploration of indiscriminate friendliness within children. In this review, research on maltreated children was excluded due to schools of thought outlining that different attachment processes were taking place within the two populations. As attachment has not been indicated within the development of IF, it would be interesting to put the research of these two populations together. Understanding more about the concept within a heterogeneous population, may allow researchers to sift out mechanisms that may be predicting and maintaining IF.

Further research indicates the use of validated observational measures to assess indiscriminate friendliness, such as the RISE, along with validated questionnaires, to ensure that the complexity of the construct is captured. Previously used semi-structured interview protocols, such as the 5IF, need to be validated so that the measure can be used reliably in other studies.

In conclusion, this literature review has found that indiscriminate friendliness may not be a symptom of disordered attachment, and may be a standalone construct in its own right. The studies in the review have been evaluated, finding sample biases and highlighting a lack of standardised measurement within this field. The review points towards further research focusing on the context and upbringing of children, both during and post-institutionalisation.

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EXCL REFERENCES, TABLES AND FIGURES

Service Improvement Project

An evaluation of a group for caregivers

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I aim to submit this to the Clinical Psychology Forum. This journal was chosen due to its interest in small scale studies that have been carried out within a clinical setting. The word limit for this journal is 1000-2500 words including references (see Appendix D) and a 50 word summary instead of an abstract. Due to the university word requirements, the current write-up was required to be 3000-5000 words. This will be amended for submission.

Summary

This study describes the development of a new group using psychological approaches for caregivers of individuals with dementia. This follows consultation with the service and its users, to the implementation and running of this group. Thematic analysis was used to extract key themes on the utility of the group. Barriers to intervention have been identified, and further research recommendations have been made.

Introduction

Alzheimer's disease is a condition affecting approximately 820,000 people in the UK, with this figure set to rise in the next 50 years (Department of Health, 2012). Of these individuals, approximately 65% are cared for at home by a loved one (Carers UK, 2012), saving the economy over £87 billion (Buckner & Yeandle, 2007).

The National Institute for Clinical Excellence (NICE) (2013) have called for an integrated approach from health and social care services to ensure carers needs are assessed effectively, as this has been shown to be linked to the health needs of the care recipient (Ablitt, Jones, & Muers, 2009). However, the role of the caregiver is increasingly being recognised as one that causes "enduring stress and frustration" (Butcher, Holkup, & Buckwalter, 2001).

The concept of caregiver burden has been defined as 'a multidimensional response to physical, psychological, emotional, social, and financial stressors associated with the caregiving experience' (Kasuya, Polgar-Bailey, & Takeuchi, 2000). A model of caregiver burden has been proposed that looks at various elements that contribute to the stress process of caregiving. This includes the carers background; primary stressors that are caused by caregiving; secondary stressors that originate outside the caregiving situation, such as poor physical health and negative social interactions (Pearlin, Mullan, Semple, & Skaff, 1990).

It has been identified that caregiver difficulties can lead to early institutionalisation for the care recipient (Etters, Goodall, & Harrison, 2008) as high levels of caregiver burden, as well as family dysfunction and decreased social support have been shown to be higher in individuals who institutionalise care recipients compared to those who do not (Spruyette, Van Audenhove, & Lammertyn, 2001).

Such research has led services to provide psychosocial interventions for caregivers, based on the variables in Pearlin's (1990) model. There is a body of evidence supporting psychosocial interventions for carers, but unfortunately there remains a lack of sufficient evaluation (Glendinning et al., 2009). The term 'psychosocial interventions' encompasses a range of approaches, models and methodology, which makes it difficult to draw comparisons between studies (Thompson et al., 2007).

Meta-analyses have explored the efficacy of different types of carer interventions, with a combination of approaches being shown to be helpful. These include psychoeducational approaches with active participation (Pinquart, 2006), the social components of a group intervention (Cooke, McNally, Mulligan, Harrison, & Newman, 2001), and problem solving/behaviour management strategies (Pusey & Richards, 2001). However, these interventions show only modest outcome results. All studies emphasise individualised approaches for caregivers, for example, supporting carers to develop their own goals and follow these through (Pusey & Richards, 2001).

Thompson et al (2007) carried out a systematic review of support interventions for this population. They found very little evidence that one-to-one interventions work for this population. Group based interventions, however, were found to cause a significant change in depression.

In terms of the findings from group interventions, Fung et al (2002) evaluated a group intervention for carers of dementia, and found that distress levels significantly decreased and Quality of Life (QoL) increased. In contrast, a much earlier study (Haley, Brown & Levine, (1987) found

that group interventions did not yield significant results on objective outcome measures. However, at follow up (2 years later) individuals rated their experience in the group as highly positive and were able to identify information learnt and goals met (Haley, 1989). The nature of measures that are used for this non-clinical population are questionable and raises the possibility of different evaluation approaches, such as qualitative methods.

Group based interventions can generate reciprocal support by individuals in similar situations, and have been shown to produce improvements in caregivers' social support (Toseland, Rossiter, Peak, & Smith, 1990). As support networks have been found to have a moderating effect on psychological distress, this is a key intervention that can have an impact on caregiver burden (Matt & Dean, 1993).

Whilst psychological interventions have a varied evidence base there are clear advantages for group based approaches, for example building a social support network which therefore impacts on psychological distress. At the moment research is unable to indicate one approach or area of intervention as more potent than others. In consideration of the literature outlined, the current study aims to evaluate a group based intervention for carers of individuals with dementia. The group aims to increase social support, whilst having a positive impact on psychological outcomes.

A local context: Post-diagnostic interventions for carers within 2gether NHS Foundation Trust in Gloucestershire

Following dementia diagnosis, educational programs (Managing Memory 2gether) are delivered to give factual information to families. These are run by a variety of professionals within the service, and are centrally designed by a multi-professional group.

Historically there has been a referral pathway in the Community Mental Health Team for carers to receive time-limited, one-to-one psychological

input for emotional management and exploration of burden, for those that have been identified by clinicians as requiring more assistance.

Informal discussions with carers and clinicians identified that social isolation was an unmet need within the service, and it was hypothesized that a group setting would meet this need.

Background

The aims of the current carers group were developed in consultation with carers of individuals with dementia. These carers had already received a service from a Clinical Psychologist.

Seven carers were consulted using questionnaires and meetings. Carers stated they found it helpful to talk through issues and concerns, and agreed that a supportive group run using psychological approaches would be useful.

A consultation session was held with members of the multi-disciplinary team (MDT). This consisted of nurses and occupational therapists who felt that a supportive group using psychological approaches would benefit the service. This was a separate need to the educational groups as the MDT reported there were many psychological issues that carers deal with, as well as the practical need for sustainable support that can continue beyond the capacity of services.

Consultation with the Psychology service took place to explore the current psychological input received by carers. Psychologists see carers for 3 to 4 sessions on average, giving them a space to reflect on their situation. In these sessions Psychologists adopt an integrative approach, and draw from a range of therapeutic models, including Cognitive Behaviour Therapy (CBT), Mindfulness Based Cognitive Behaviour Therapy (MBCT) (Teasdale et al., 2000), Compassionate Mind Theory (Gilbert, 2010), Positive Psychology (Seligman & Csikszentmihalyi, 2000), Brief Solution Focused Therapy (De Shazer, 1985) and Narrative

Approaches (White & Epston, 1990). Due to the multi-dimensional nature of caring (Pearlin, et al., 1990), approaches are integrated to ensure they are person-centred and targeting areas that the caregiver wishes to focus on.

The Psychology service discussed evaluations of caregiver burden, and hypothesised that outcomes may increase following a short piece of work. This may be due to the heightened awareness of one's own emotions.

Carers Group sessions

Based on the consultation, a 6 session programme was developed that aimed to meet the needs of carers and the service.

Session 1 – Introductions and goals. The aims of this session were to introduce group participants to each other, for group participants to create individual SMART (Specific, Measurable, Achievable, Realistic and Time-limited) goals for the end of the group.

Session 2 – Emotions. The aims of this session were to share experiences with others, give compassionate advice to others and practice being compassionate to themselves.

Session 3 – What makes things better, what makes things worse. The aims of this session were to have a balanced idea of the positives and negatives in individuals' lives, and relate this to their own situation.

Session 4 – Loss and grief cycle. The aims of this session were to discuss loss as a journey, discuss the concept of "acceptance" and what this may look like for them.

Session 5 – Problem solving practice. The aims of this session were to practise solving practical problems step-by-step.

Session 6 – Reflections and ending. The aims of this session were to end with writing a compassionate letter to themselves and reviewing personal goals.

Each session ended with a 10 minute mindfulness/compassionate mind exercise.

Aims of the study

- To develop and run a group for carers of adults with dementia based on findings from the literature and consultation with the service.
- To reduce caregiver burden and increase QoL, as a direct result of the group, as measured by standardised tools
- To evaluate the group qualitatively to assess subjective gains.
- To provide feedback to the service regarding both the process and the outcomes of the group.

Methods

Procedure

University of Bath ethical approval was sought and granted, before getting permission from 2gether NHS Foundation Trust R&D department.

During consultation with members of staff and service users, the rationale for the study and the procedure was explained. Individuals were invited to ask questions, and verbal consent was received from all parties.

Referrals for the group were received from the multi-disciplinary Older People's Community Mental Health Team. All participants were given a detailed Participant Information Sheet about the study, and asked to sign a Consent Form to take part in the study.

The following questionnaires were used to evaluate factors known to be associated with caregiver stress, and were administered pre & post intervention:

- Zarit Carer Burden Interview (Zarit S. H., Reever K. E., & Bach-Peterson J., 1980). This 22 item questionnaire asks questions of carers to rate their level of burden on a 5 point scale. Questions consist of items about feelings, physical strain and concerns about the future.
- World Health Organisation Quality of Life (WHOQOL-BREF; (Skevington, Lotfy, & O'Connell, 2004). This 26-item questionnaire is a shorter version

of the original that aimed to assess quality of life cross-culturally. It asks questions on broad domains of quality of life, such as physical health, psychological health, social relationships, and environment.

- Patient Health Questionnaire 9 (PHQ 9; (Kroenke, Spitzer, & Williams, 2001). This is a 9 item questionnaire that is used to assess and monitor depressive symptoms, based on the DSM-IV diagnostic criteria. It has 61% sensitivity and 94% specificity in adults.
- Generalised Anxiety Disorder Assessment 7 (GAD 7; (Spitzer RI, 2006). This is a 7 item questionnaire that is used to assess and monitor symptoms of generalised anxiety disorder. It is also moderately good at assessing symptoms of panic disorder, social anxiety disorder and post-traumatic stress disorder.

Qualitative feedback was gathered through a focus group that took place one month following completion of the carers group. The focus group facilitator was a different person to the group facilitator.

Participants

Out of the 10 potential participants invited to the carers group, only 3 were able to attend. Telephone invitations to potential participants indicated that barriers (such as difficulty accessing the clinic, and lack of respite care for the care recipient) prevented individuals from attending the group. The 3 participants were female and of White British origin (aged 54-82). Two cared for their spouses, and one for her father, all with a diagnosis of Alzheimer's disease.

Two participants were able to attend the qualitative focus group. These participants were the two who cared for their spouses. The third participant was unable to attend the focus group due to personal commitments.

Focus group methodology

The focus group interview was semi-structured in nature and consisted of one main overarching question, and three specific questions that were asked about the nature of the group. These questions were:

Overarching: "What was the carers group like?"

Specific: “Has there been a change in the way you deal with things?”

“Were 3 participants too few/too many for the group?”

“What was it like having different caring roles within the group –
i.e. 2 spouses and 1 daughter?”

Epistemology

The epistemological stance taken by this analysis is an essentialist/realist approach. This reflects the assumption that language reflects meaning and experience, rather than language being socially constructed

Whilst there was a clear purpose of the focus group - to evaluate participants' subjective views of the carers group - the analysis was carried out in an inductive way. This was so that themes may have been identified that did not have a direct link to the group experience. The potential relevance of such themes to the current group experience, and the design of future groups, was believed to have clinical value.

The analysis was carried out at a semantic level, as themes were identified by closely assessing the data. There was a progression from describing the statements made in the focus group, to interpreting the broader meanings and implications of the data.

Analysis

The focus group took 46 minutes. The data was audio recorded, transcribed verbatim and analysed using the Braun & Clarke (2006) model of thematic analysis.

Firstly the data was listened to on three occasions in order for the researcher to be immersed within the data. The data was then transcribed and read carefully in order to identify meaningful units of information that may or may not be relevant to the focus group question. This “coding” was done twice with the data set. The “codes” were then grouped together into categories, where statements were found to denote similar meanings. The same statement could be included in more than one category. Finally, the categories were reviewed to see whether they appropriately matched the

data set, and whether there was enough evidence to back up the categories identified.

A second researcher read through the data independently and there were a number of discussions to reach consensus about the final coding. A third researcher, who was external to the study, reviewed the transcription and generated themes based on reading the data. Overall agreement of themes was good, and it was reported that the themes were grounded in the data.

Results

Three participants completed questionnaires at the beginning of the group, and two completed questionnaires at the end. Due to the lack of repeat data, it was not possible to carry out analyses. See Table 1 for the scores:

Table 1: Results

	<i>Time 1</i>							<i>Time 2</i>						
ID	PHQ 9	GAD 7	QoL- D1*	QoL- D2**	QoL- D3***	QoL- D4****	Caregiver Burden	PHQ 9	GAD 7	QoL D1	QoL D2	QoL D3	QoL D4	Caregiver Burden
1	7	7	44	63	69	81	29	6	5	44	63	50	69	30
2	6	2	50	56	50	69	42	5	1	44	56	69	75	47
3	17	21	38	44	56	63	41							

*Domain 1 measures physical health

** Domain 2 measures psychological factors

*** Domain 3 measures social relationships

****Domain 4 measures environmental factors

All participants met individualised goals that had been set at the beginning of the group. Within a qualitative group evaluation questionnaire, all participants stated that the group was of value to them and that they would stay in touch with the other group members. Longitudinal analysis will be helpful in monitoring whether this has been maintained.

Focus Group

The thematic analysis resulted in 2 overarching themes, with 3 subthemes in each. These were as follows:

- Experiences of being a carer
 - o The strain of caring
 - o Disbelief
 - o Feeling alone
- The impact of the group
 - o Interactions with others
 - o Emotional release
 - o Changes following group

Experiences of being a carer

Participants spoke in great detail about what it was like to be a carer of an individual with dementia. Ideas and themes were often communicated using stories and recent examples from everyday life.

Sub themes of this category were:

- The strain of caring: Participants described how difficult caring can be and the emotional impact that this has. Participants discussed feelings of “tiredness” and how tasks can, at times, be laboured and difficult:

“So I think evenings are the worst for me, and late afternoons perhaps, cos in the day you’re sort of busy aren’t you, well trying to be.” (P1)

“Every day now, for the last nearly a month, every day, not just once but 4 times in an hour “Do I have to mow the church”, and then I say “no” and then it’s “why” “how do you know” and I have to go through the whole thing, what I said. But it doesn’t go in, does it (...) But the thing is, it’s very hard” (P1)

But I think he can tell by the tone of my voice (laughs) that I’m getting tired. And I just say “I did tell you” and he’ll say something else and I’ll say “I did tell you” (P2)

- Disbelief: The participants discussed their own feelings of disbelief at the current condition of the care recipient. They did this through telling stories describing how the care recipient used to act, and then an example of how this is different now. There are also examples throughout the focus group, of other’s experiencing disbelief.

“This is what I find hard, somebody that just loved a cup of tea” (P2)

“Our middle daughter, I said she still can’t believe it cos she says to him, if (X) says something she’ll say “are you having me on Dad?, are you joking?” and he says “no I can’t remember” she says “but we only talked about it 10 minutes ago” (laughs) I don’t think she can really quite believe” (P2)

“But I just can’t believe that somebody who was so good at figures, so good at his job, is like he is.” (P1)

- Feeling alone: Participants discussed feeling alone practically, in terms of being isolated. Participants also discussed feeling alone in terms of expressing emotion, and how this is difficult to do when being the sole carer for an individual with dementia.

“You sort of shut yourself off a little bit.” (P1)

“And also I found myself not telling anyone for a long time, and it was getting noticeable” (P1)

“Yeah cos I do think, you know my friends say “how’s (X)” and I say “oh he’s fine” you know, you don’t want to feel like saying, “well he’s really like this”, well they’ll get fed up won’t they, they don’t want to know” (P2)

The Impact of the Group

The focus group questions led participants to discuss the impact of the group. The key sub-themes linked to this were:

- Interactions with others: Participants expressed positive emotions associated with listening to others about their experiences. Linked to this, recognising others’ experiences also formed a positive part of how participants viewed the dementia, and how they viewed their partner. Recognising experiences led to a feeling of normalisation between the group and shared understanding.

“Well it was very interesting. It was nice to hear, and listen to everyone and what was happening” (P2)

“Bit comforting to think, it’s just something he’s doing that I’m picking up on.” (P1)

“It did certainly help to know there were other people with the same type of things going on, albeit different temperaments whatever. But the same sort of things, having to deal with, so it was quite nice to know” (P1)

- Emotional release: Participants discussed the expression and release of emotions in the group as being a “nice” feeling, and one that does not happen in other settings. However, there was also recognition that the group would lead to participants feeling “drained” as a result of the emotive topics discussed in the group.

“um, it was nice to be able to sometimes burst everything out that’s inside you that you want to say and you can’t say to family sometimes” (P1)

“...and you are sort of bringing out all your emotions, you’re bringing out your worries.” (P2)

“I think when you got home, and you sort of had to rearrange your brain a little bit. It was in your head for a long time” (P1)

“P1: Yeah it was quite draining, did you find that?”

P2: Yeah, I felt shattered when I got home”

- Changes following group: Participants discussed things that had changed after having completed the group. This consisted of changes in perspective, as well as things that were practically being done differently. It is worthwhile noting that this sub-theme was only defined by one participant’s responses. However, these were mentioned on a number of occasions and therefore were felt to warrant a sub-theme.

“...like contact people that I hadn’t, you sort of shut yourself off a little bit. I contacted different people that I hadn’t contacted for a long time” (P1)

“There were things like when they were explained a different way to, I felt quite interested that I hadn’t picked up on. Things that (facilitator) sort of said to us, goals and things to set.” (P1)

“So I think it was admitting a little bit that something had changed and then they just fell into place those things.” P1)

See Appendix E for full list of quotes associated to themes. Thematic maps were also constructed to demonstrate the process of deriving themes from the data. See Appendix F and G.

Different caring roles

One of the questions of the focus group was:

“What was it like having different caring roles within the group –
i.e. 2 spouses and 1 daughter?”

Whilst no themes were found associated with this question, it is of note that the two participants in the focus group stated that their experience was positive. Participants noted the differences between their experiences, and that of the third participant, but did not state that this was an issue. However, participant 1 reminisced about looking after a parent who had experienced dementia, and highlighted a range of feelings, such as anger, guilt and intense sadness. These emotions were not highlighted about their current caring role related to their spouses.

Service feedback and recommendations

The study was presented to the Psychology service following completion of the group to outline strengths and areas that the group could improve on.

The small sample size was identified as being an area that limited the conclusions that could be drawn from the study. The service identified that this was a common issue observed in new groups within the service, and they were confident that there would be more referrals and group members once the group was well known within the service.

Other reasons behind the small sample size were also considered.

Reasons around non-attendance to the group fell into two categories:

- access to the group, such as difficulties arranging transport and getting to the clinic
- respite care for the care recipient.

These barriers to intervention are worth considering for the service, as further thought may need to be given as to how to access this hard-to-

reach population. Ideas around how to overcome these barriers were discussed, including utilizing the internet, and making the most of the time that the care recipient spends in appointments within the service.

There may also have been other barriers preventing individuals from coming to the group. This group defined itself as psychological in nature, and outlined goals that were around exploring feelings and emotions. This can feel difficult for some caregivers who do not see themselves as 'service users'.

Linked to this, there were discussions about the group setting, and whether an NHS clinic was the best place to carry out a carers group because of its connotations of ill-health. A way of overcoming this barrier may be to carry out carers groups within a community setting, therefore reducing stigma of help-seeking behaviour, and increasing access to the group.

The service plans to continue the group, and implement the model within other areas of the service. The recommendations for future groups, based on the results of the study and discussions with the service are as follows:

- To ensure that each group has more than 2 members, as participants valued sharing and listening to different experiences.
- For each group to be approximately 1.5 hours, including a break in the middle. This is to take into account that the group was felt to be "draining".
- To link the idea of "disbelief" to the loss and grief cycle, highlighted in session 4.
- To explore with group participants whether to make goals around "feeling alone".
- To potentially add an extra session to allow participants to only share experiences and stories. As the focus group was appreciated and utilised in this way, group participants may find this helpful.
- To explore carrying out the carers group in a community setting.
- To explore utilizing the internet to deliver a group online.

- To explore providing carer support whilst the care recipient is having an appointment in the clinic.
- To work with members of the system/voluntary agencies to ensure that respite care is possible for the carer to attend the group.
- To explore paid transport options for carers groups.

The discussion around barriers to intervention in this population has encouraged the service to take these into account when planning the next group.

Discussion

Literature has demonstrated a lack of conclusive studies in the field of caregiver interventions. Even though the evidence base is limited, clinical experience suggests that services commonly utilize groups as a way of providing psychosocial support.

Prior to discussing the results, the limitations of the study must be considered. Firstly the white, female sample was not representative of the region, and is problematic as we are unable to generalize the results to different cultures and genders.

The extremely small sample size was an issue. Significant conclusions regarding quantitative results cannot be made from such a small sample size and it would be important to replicate the group to add to the existing data.

The group contained a wide range of ages (54-82 years), with different caring roles being represented (i.e. daughter and spouse). However, it must be noted that the third participant, who was the only participant to not return questionnaires and attend the focus group, had a different caring role to the other two participants. This may have had an impact on the third participants' experience in the group, and it is unclear whether this contributed to the lack of completed questionnaires and missed attendance at the focus group.

It is also worth noting that the third participants' depression and anxiety scores differed significantly to the other two group members. As participant 3 scored in the clinical range for depression and anxiety, this also raises issues around the suitability of including this data alongside the other two participants. Due to the small sample size, data that differs significantly at baseline is likely to skew the results thus making the quantitative data inconclusive. In order to carry out quantitative statistics, it would be essential to collect more data from carers groups.

This study, like the literature it samples, has found variable results. Statistically, it has not been possible to quantitatively evaluate the impact of the carers group. The measures taken do not show a change in caregiver burden, depression, anxiety or quality of life. However qualitative feedback indicated that the group was useful for participants to share experiences with others, to allow an "emotional release", and also to generate change in terms of perspective, as well as in terms of practical things that were done differently following the group.

The focus group also highlighted issues that were pertinent to caregivers of individuals with dementia. These were specifically around the strain of caring, feeling alone, and the disbelief about the current state of the care recipient. These specific issues are potentially areas for further research, and could form the focus of future interventions with this population. The subthemes identified in this study could be linked in with the future groups, and have been fed back to the service as a recommendation.

Acknowledging the barriers that caregivers face in order to attend groups has been a valuable part of the process for the service, and it is encouraging that the group will be continuing in the future.

Whilst recognizing that there has been subjective value for caregivers taking part in groups, this study has also highlighted a real issue within this population – barriers to accessing services. These pragmatic barriers greatly affected numbers for this study, and this population will continue to

remain under-represented and under-tested unless the barriers are addressed. Liking the research within this field to that within parenting, it has been recognized that parents will not attend parenting courses unless they have arranged care for their children. This has been addressed within child services, but as yet has not been tackled in older adult community settings. The case has already been made that caregivers are an invaluable resource to our society. Cultural and social shifts are essential to prioritise this population, and ensure that they are able to seek the support that is needed.

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Main Research Project

An experimental investigation into young people's ability to use metaphors within therapy

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I am to submit this paper to the journal of Behavioural and Cognitive Psychotherapy. This is due to the more recent research on stories and metaphors being published in this journal. The journal also lends itself to more experimental pieces of research.

Abstract

Background: Metaphors are commonly used within clinical settings to communicate concepts to young people. Whilst theories of how metaphors work have been proposed, alongside ideas to implement metaphors effectively, there has been little research as to whether metaphors impact memory and understanding, in comparison to basic language. **Aims:** The current study aims to assess whether metaphorical explanations leads to improved memory and understanding for psychological concepts. **Method:** 25 participants took part in the study (10 boys and 15 girls). Individuals who were on the waiting list for Cognitive Behaviour Therapy (CBT) were given the opportunity to watch a video which explained the main concepts of CBT. Half of the participants watched a video with metaphorical explanations (Metaphor group); the other half saw a video using basic language (Psychoeducation group). The participants answered questions immediately after the video and then four weeks later, on psychopathology, memory and understanding measures. **Results:** T-tests were carried out to determine any differences between the two groups. There were no significant differences on all variables tested (memory, understanding, intention to change) immediately and after four weeks. Correlational data, looking at the link between age and understanding/memory between the two groups found that older individuals were more likely to understand and remember the content of the Psychoeducation video. Whilst this correlation did not differ significantly from the Metaphors group, there were no such trends for individuals exposed to a metaphorical understanding. **Conclusions:** Definitive conclusions cannot be made due to methodological concerns so there is a call for further research in this area. Preliminary results indicate that metaphors do not appear to enhance memory and understanding of young people, in comparison to basic language. However, it seems they are equally understood by younger and older children, therefore making them an accessible way of communicating complicated concepts.

Introduction

Metaphors are widely used in therapeutic conversations to convey difficult concepts, and increase memory (Stott, Mansell, Salkovskis, Lavender, & Cartwright-Hatton, 2010). They are creative, linguistic tools used to liken and associate two unrelated concepts, and have come to be used heavily in the English language to denote a stylistic use of understanding. A well-known example of this would be Shakespeare's frequent likening of life and theatre, such as "The world is a stage, and all the men and women merely players" (Shakespeare, *As you Like it* 2/7). However, many metaphors are not so noticeable as they are a part of daily language, for example the idea that life is a journey (Lakoff & Johnson, 1980). It is these more subtle metaphors that have been claimed to be crucial to the development of new cognitive concepts. As therapy aims to do this, it has therefore been hypothesised that metaphors are a useful part of this process.

Metaphor, as a broad term, can be described in the form of stories, analogy, and imagery. Therapists have traditionally used a range of creative tools to allow individuals to access complex psychological concepts and ideas, with a view to then helping them change key meanings.

Children, and those with lower developmental abilities, have been observed to have difficulty understanding complex and abstract points in therapy (Creed, Reisweber, & Beck, 2012). It has been questioned as to whether Cognitive Behaviour Therapy (CBT) is developmentally appropriate for children (Grave & Blissett, 2004) due to the use of the rationalist paradigm and the level of cognitive ability that is required. In line with Piaget's (1962) theory of cognitive development, it is understood that children will be at varying stages in their ability to relate to abstract and non-concrete information. Metaphors have therefore been used as a "cognitive bridge" (Richards, 1965) to assist this process and have been found to be clinically useful for therapists to explain abstract concepts, such as the cognitive model, in a concrete way (Creed, et al., 2012).

The use of metaphors in making sense of existing meanings and arriving at new ones is an old phenomenon. Lakoff and Johnson (1980) described the “conceptual metaphor” framework, stating that metaphors are at the centre of our understanding of concepts, rather than just a linguistic feature. It was claimed that metaphors are extended to denote internal schemas (Allbritton, 1995). An example of this would be the metaphor that “an argument is war”. We describe *winning* an argument, *attacking* weak points in the argument, calling a *truce*, etc. Therefore the claim is that our understanding of what an argument is, has been shaped by the metaphor that has most commonly been used to describe it.

Lakoff and Johnson suggest that such processes are fundamental to cognitive development. They hypothesised that mapping between conceptual domains could lead to mapping between neural networks. However, this hypothesis has never been tested. The authors outlined a ‘conduit metaphor’ in order to demonstrate the mechanism of metaphors. They used the idea of a speaker placing ideas into a container, sending them along a channel (or conduit), with the listener taking ideas out of the container, and making their own meaning out of it. This has been claimed to be the essence of what a metaphor will do.

Recent theoretical and clinical observation describes the use of metaphor, and claims that metaphors and story-telling can aid memory within therapy acting as a kind of cognitive enhancement (Otto, 2000). A fundamental hypothesis of metaphor use is that they may offer a type of “cognitive bridge”. Richards (1965) originally introduced this theory, but it has been developed over the years (Stott, et al., 2010). Therapy can benefit from this idea as metaphors can be the link between well established and problematic meanings of the self, to alternative, newer and more helpful meanings.

It has also been hypothesised that metaphors can increase insight into the nature of one’s current difficulties (Barlow, Pollio, & Fine, 1977). Whilst the concept of ‘insight’ may be problematic to define (Sternberg & Davidson, 1995), it has been claimed that following ‘insight’, behaviour

change is imminent (Bryant, Katz, Becvar, & Becvar, 1988). This implies that metaphor is associated with change in therapy, but this is yet to be tested within a clinical setting.

Little is known about the efficacy of metaphors, and the mechanisms that drive it. Bayne and Thompson (2000) identified that the literature currently consists mostly of “case studies and speculation”. Stott et al. (2010) indicated that metaphor use has also been a longstanding therapeutic tool in a range of approaches, such as Psychodynamic therapy, Acceptance and Commitment Therapy and Cognitive Behaviour Therapy. Therefore it is a common feature of the range of methods employed by therapists of different orientations. Creative tools, such as metaphor use, have been explored in more detail recently, advocating its use with a range of populations (Blenkiron, 2005; Friedberg & Wilt, 2010; Mooney & Padesky, 2000).

An older review (McCurry & Hayes, 1992) carried out exploring how metaphors “work”, identified potential ways that metaphor use could be evaluated. This was by focusing on memorability and comprehensibility. It was claimed that very little research has been successful in evaluating whether memory or comprehension are affected by metaphor use. Occasional studies support the claim that metaphors increase comprehension (Hoffman & Kemper, 1987), however, methodological flaws prevent these studies from making a strong therapeutic argument. McCurry & Hayes (1992) go on to identify developmental issues with regard to comprehension in children and young people. There are claims that children start spontaneously producing metaphors from the age of four (Carlson & Anisfeld, 1969; Piaget, 1962); however, the question arises as to whether this means that children comprehend metaphors that are told to them. Literature in the 1970’s states that they cannot (Cometa & Eson, 1978; Smith, 1979; Winner, Rosenstiel, & Gardner, 1976). Studies showed that children were unable to understand the figurative nature of the metaphor, and took the phrase literally. For example, Winner et al (1976) found that children under the age of 14 were not able to fully explain the meaning of some metaphorical examples such as “The prison

guard was a hard rock”. However, criticisms arose around the methods of data collection that were used within these studies, and it was argued that these studies may not have been indicating a failure to comprehend metaphors, but a failure of participants to communicate their ideas linguistically. Many of the studies asked children to paraphrase or explain the metaphor, which is not consistent with their developmental abilities (Vosniadou, 1987). Vosniadou (1987) identified studies showing children as young as 4 years old were able to comprehend metaphors. However, this was demonstrated through age appropriate means, such as play enactment, or by offering multiple choices. This claim has not been properly tested, and research which has been done was not tested in a clinical environment.

The literature (Blenkiron, 2005; Friedberg & Wilt, 2010; Otto, 2000; Varra, Drossel, & Hayes, 2009) continues to promote the use of metaphors, in the absence of evidence for its value.

The current study’s primary aim is to fill a gap in the literature surrounding metaphors by empirically testing whether using a metaphor to demonstrate a concept can lead to significantly better understanding and retention of concepts, than straight forward explanation. A secondary aim of the study is to determine whether there is an age difference in the utility of metaphor delivery between younger and older children

Methodology

Design

The study was designed with the aim of recruiting 38 participants, with 19 in each group. This was based on the g*power calculation of power = 0.8, α error probability = 0.1 and a medium-high effect size of 0.7. However, as recruitment proved difficult, the final number of participants was 25, thus impacting on the power of the study.

Participants

The final sample consisted of 25 young people, with an age range of 6-17 years. There were 10 boys and 15 girls, all recruited from 2gether Trust Improving Access to Psychological Therapies (IAPT) pathway within the Children and Young People Service (CYPS). The racial make-up of the participants was predominantly White British (96%), with only one participant having a mixed Afro Caribbean and White British ethnicity. All participants were recruited whilst being on the waiting list for Cognitive Behaviour Therapy (CBT) for anxiety.

None of the participants were subject to a cognitive assessment to ascertain developmental level. However, all young people received an initial assessment from the service, and all those referred to the IAPT pathway were assessed to be appropriate for CBT in terms of intellectual ability.

All participants completed the initial part of the study and 14 participants provided follow up data to the study.

Participants were randomly allocated to one of two groups (Psychoeducation or Metaphors). A random number generator was used to randomise and participants were stratified by gender in blocks of 4.

Descriptive statistics were carried out on predisposing participant information. Each group was normally distributed. Age demographics have been outlined in Table 1.

Table 1: Age demographics

	Metaphor group (mean)	Metaphor group (SD)	Metaphor group (range)	Psychoed group (mean)	Psychoed group (SD)	Psychoed group (range)
Age	13.75	2.29	9-16	12.92	3.71	7-17

Analyses were run to assess whether there were pre-existing differences between groups on age, number of parents and number of siblings. See Table 2.

Table 2: Differences between groups

	Metaphor group (mean)	Psychoeducation group (mean)	Statistic (t/X ²)
Age	13.75	12.92	T (22) = -.73 (n.s)
No. of parents	1.64	1.62	T (22) = -.101 (n.s)
No. of siblings			X ² (3) = 1.510 (n.s)

*indicates a significant difference where $p < 0.05$

Participants referred to IAPT for depression, or conduct behavioural issues were excluded from the study because the content of the study did not fit into the treatment package for these individuals.

Procedure

The study obtained ethical approval from the NHS Ethics Research Committee (REC reference number: 13/NI/0082), and approval from 2gether Trust R&D department.

Participants were recruited from the Children and Young People Service (CYPS) Improving Access to Psychological Therapies (IAPT) pathway. Young people referred to this pathway have problems with depression and anxiety, with more complex presentations being referred elsewhere. Only young people with anxiety were invited to take part in this study.

All parents and young people took part in an initial assessment with CYPS where they completed a number of outcome measures including the Revised Child Anxiety and Depression Scale (RCADS). Parents and young people who were eligible for the study were sent a letter outlining the possibility of being contacted to invite them to take part in a research study. At this point parents and young people could opt out of taking part.

There was approximately a 6 week waiting list for individuals referred to the IAPT pathway. During this time they wait to see a therapist to receive Cognitive Behaviour Therapy (CBT). In the 6 week waiting period, parents and young people were contacted by the researcher to see whether they would like to take part in the study. Once they expressed initial interest, they received a Participant Information Sheet, Consent form and a letter inviting them to the clinic with an appointment time. Following receipt of consent, the participants were asked to complete the Children's Cognitive Behavioural Avoidance Scale (CCBAS).

The study was delivered through a specially produced video explaining the model and the key defining features of anxiety, which was narrated by three people engaging in conversation about CBT.

Following presentation of the video, a focused set of questions was asked to participants to see how much they remembered and understood from the video.

Four weeks following the presentation of the video, participants were invited back into the clinic to complete follow-up measures. Participants filled in the CCBAS and the RCADS, as well as answering questions about their memory and understanding of the video they watched four weeks earlier.

At this time participants were also debriefed with information about what experimental condition they were in. Participants were given a copy of both videos on a DVD.

Participants that were unable to attend the second clinic appointment were invited to complete the memory and understanding measures on the telephone. This was so that the maximum number of participants were still able to complete the second part of the study without going over the four week time point, thus making results incomparable.

Materials

Video

A “Preparation for Treatment” video was utilized in the study, which contained basic CBT psychoeducation intended to socialise individuals to the therapeutic model and generate a basic formulation for participants to gain an understanding of their difficulties. Psychoeducation often forms the basis of cognitive behavioural therapies in the first instance. Avoidance and safety seeking behaviours have been chosen as topics to be delivered in the study due to their relevance in anxiety, and their transdiagnostic qualities (Harvey, 2004).

The content of the videos was focused around three main concepts: that avoidance can maintain anxiety; that safety seeking behaviours can appear to reduce anxiety for a time but can lead to a worsening of symptoms; and the concept of the anxiety curve, so that individuals can “ride the wave” of anxiety. Concepts and metaphors were taken from Paul Stallard’s (2003) *Think Good Feel Good* workbook for young people as well as literature on metaphor use in Obsessive Compulsive Disorder (Waite & Williams, 2009).

There were two versions of the same video, which varied only in the use of metaphor to communicate the importance of avoidance in anxiety. One video used basic language to demonstrate certain concepts, with the other video using metaphors to demonstrate the same concepts. In both videos, a basic description was given about the concept, as well as an example that was performed by one of the actors. This example was about being scared of going to school. The Metaphor video then went on to describe a well-known story used to demonstrate the pitfall of safety-seeking

behaviours, known as “the salt and the alligator story” (Waite & Williams, 2009). The Psychoeducation video gave another basic description about the concept. For a script of the video see Appendix H. Both videos were the same for approximately 5 minutes throughout the course of a 7 minute video.

The desire to decrease threats to validity led to the decision not to differentiate the videos for different age groups. If different videos were created for different age ranges (for example, if the video for younger children was more engaging, and enthusiastic), it would be difficult to distinguish whether memory for concepts were due to the metaphorical explanation, or the enthusiasm and engagement of the video. Language was kept at a basic level throughout the videos so they were understood by both age groups.

Measures

The measures for this study were a combination of both questions specifically relating to the video made for this study, and standardised questionnaires assessing avoidance and psychopathology.

The development of specific questions took place through assessing the script for key themes. It was important that the questions applied to both videos, so questions were not focused around the metaphors themselves. This was done under supervision and clinical guidance.

- *Specific Questions*

1) Memory

Immediate memory was assessed by asking participants to freely recall what they could remember from the video, just after they had watched it.

It was scored by coding responses based on essential pieces of information. Inter-rater reliability was carried out by two assessors. These assessors scored all questions for three participants’ answers. Reliability was assessed as being $r(3) = .952$. See Appendix I for scoring manual.

2) Understanding

To assess understanding of the concepts, further questions were asked. This included questions about how the participants made sense of the information they were exposed to, and whether they were able to abstract this information to apply in other settings. These questions were asked by the researcher in the form of an interview. Inter-rater reliability was carried out by two assessors. These assessors scored all questions for three participants' answers. Reliability on this subscale was assessed as being $r(3) = .929$.

Please see Appendix J for these questions.

3) Intention to change

In the interview, one question was asked to the participants about their intentions to change based on what they saw in the video. This question was worded as: *"How much does this video make you want to do things differently when you feel anxious?"* Participants' rated their intention on a scale of 0-100. They also outlined specific activities they could do following the viewing of the video.

4) Delayed recall

Approximately four weeks after the delivery of the video, participants were asked to recall what they could remember from the video. This was carried out in the clinic with the first author, and scored in the same way as the immediate recall measure.

- *Standardised questionnaires*

1) Children's Cognitive and Behavioural Avoidance Scale (CCBAS)

This scale was adapted from the Cognitive and Behavioural Avoidance Scale (CBAS) (Ottenbreit and Dobson, 2002) to measure participants' level of avoidance, before watching the video, and four weeks after watching the video.

The adult version of the scale has a reliability coefficient of 0.92, and has shown good convergent and divergent validity. The authors gave permission to edit the scale for children. For a copy of the adapted scale, see Appendix K. Some items may have been difficult for younger children to access, for example items about motivation to go to social events. On these occasions parents were advised to provide assistance to young children.

2) Revised Child Anxiety and Depression Scale (RCADS) for young people and parents (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000).

The RCADS is a 47 item self-report questionnaire assessing anxiety and depression psychopathology. The subscales include: separation anxiety, obsessive compulsive disorder, panic disorder, social phobia, generalised anxiety disorder and major depressive disorder. There are two versions of the questionnaire, one for young people and one for parents. Both versions were used in the study. The RCADS is routinely collected by the service when an individual comes for an initial assessment and therefore this data was used as preliminary information about participants' psychopathology. The RCADS was collected at four week follow up to see whether there had been a change in symptomology following delivery of the video.

Treatment of data

Data was entered into the statistical package SPSS. When items on questionnaires were missed out the following rules were applied:

- If 1 item was missing, the modal score of the questionnaire was used.
- If more than 1 item was missing, the scores were pro-rated.
- If 50% or more of the items were missing, the data was recorded as missing.

Data Analytic Plan

This plan was decided a priori. In order to analyse the data, statistical tests were planned to see whether there were significant differences between the Metaphor and Psychoeducation groups on a range of variables.

T-tests

T-tests were planned with the primary variable; *Understanding*, and the co-secondary variables; *Immediate Recall*, and *Intention to Change* post video.

Analyses of Variance (ANOVA)

Further analyses were planned with the subscales of the CCBAS, and the avoidance relevant subscales of the RCADS. Avoidance relevant subscales of the RCADS were calculated by adding up subscales where avoidance is a main feature of the difficulty (for example, within panic disorder or obsessive compulsive disorder).

It was planned that these scales would be analysed using a repeated measures ANOVA, looking at main effects and interactions between time (pre-video and four weeks post-video), subscale (avoidance versus non-avoidance) and group (Metaphor and Psychoeducation)

Correlations

Correlations were planned to assess the developmental impact of metaphors. Therefore *Age* was correlated with *Understanding* and *Immediate Recall* to assess whether age of participant had a significant impact on ability to understand the metaphorical explanation.

Results

The data collected immediately following presentation of the video was analysed using t-tests. These were carried out to see whether there were significant differences between the Psychoeducation and Metaphor

groups. There were no significant differences found between the groups on all variables. See Table 3.

Table 3: T-tests

	Metaphor group (mean)	Psychoeducation group (mean)	Statistic (<i>t</i>)
Understanding	6.08	6.77	<i>t</i> (23) = .772 (n.s)
Memory – immediate recall	5.82	4.84	<i>t</i> (23) = -.612 (n.s)
Intention to Change	59.42	68.77	<i>t</i> (23) = 1.250 (n.s)

Although there were no differences in the short term, the longer term data was analysed using repeated measures ANOVAs to determine whether there were any significant effects over time. Due to a high attrition rate, there were only 14 participants' data collected at follow up. This meant that analyses could not be reliably carried out and reported. See Table 4 for means from this analysis.

Table 4: Means from ANOVAs

Condition	Time	Subscale	Mean
Psychoeducation	1	Avoidance	8.907
		Non-Avoidance	7.537
	2	Avoidance	8.796
		Non-Avoidance	7.056
Metaphor	1	Avoidance	11.267
		Non-Avoidance	10.467
	2	Avoidance	10.867
		Non-Avoidance	8.800

To assess the secondary aim related to age, a correlational analysis was carried out as there were no different age groups within the study. Correlations were carried out separately for psychoeducation and metaphor groups in order to determine whether there was a

developmental effect with metaphor and basic language understanding and retention. Significant results were found with the Psychoeducation group, where older individuals were more likely to understand the video than younger individuals. There were no significant effects in the Metaphors group, indicating that metaphors may be universally understood by a range of ages. These two correlations were compared and not found to be significantly different from each other, therefore reliable conclusions cannot be made on this analysis. See Table 5 for results.

Table 5: Correlational analyses

Memory	Memory (Psychoeducation) and Age	$r(13) = .733^{**}$ ($p < 0.01$)
	Memory (Metaphors) and Age	$r(13) = .412$ (n.s)
	Significance between the two correlations	$z = 1.08$ ($p = 0.14$)
Understanding	Understanding (Psychoeducation) and Age	$r(13) = .605^*$ ($p < 0.05$)
	Understanding (Metaphors) and Age	$r(13) = .529$ (n.s)
	Significance between the two correlations	$z = 0.24$ ($p = 0.41$)

*indicates a significant difference where $p < 0.05$

**indicates a significant difference where $p < 0.01$

Different age groups were not created post-hoc to assess the developmental effect of metaphors due to the small sample size. Post-hoc age groups would have been too small to carry out reliable statistics and thus may have led to invalid conclusions.

Debriefing reactions

During debriefing, it was notable to report that nearly all participants, even those who fell into the Psychoeducation condition, believed that they were part of the Metaphors condition. When asked to discuss why this was, the participants stated that the example given to demonstrate concepts in both conditions may have also acted as a metaphor/story.

Discussion

The purpose of this study was to examine the utility of metaphors within therapy with young people. However, a small sample size has meant that

data has not been fully analysed. It has been theorised that metaphors have an impact on memory and understanding, and that this may be a useful clinical tool, but this had not been tested experimentally.

Findings indicated that immediately following the presentation of information from metaphors or basic language, there were no significant differences in understanding, memory and intention to change, between the two groups. This also appears to be so at four week follow up.

When looking at whether age was a factor, it appears that older children may remember and understand basic language better than younger children as determined by correlational analyses. Whilst there was no relationship between age and memory/understanding in the metaphors group, conclusions are unable to be drawn from this result due to the lack of significant difference between the two correlations.

It is important to view the conclusions of the study in the context of its limitations, as it is likely that the threats to validity had an impact on findings.

Limitations

The sample size of 25 participants was very small, and has led to an underpowered study. The small sample size was also further compounded by 11 participants dropping out for Time 2. This meant that it was not possible to analyse follow-up data, thus having an impact on the conclusions drawn from this study.

There were also a range of limitations relating to the methodology of the study, potentially impacting on the final results and conclusions. The video created was done under clinical supervision and guidance using literature in the field; however, in order to enhance validity, the video would have significantly benefited from piloting. This may have identified any issues with the video at an early stage. The video would also have benefited from

ratings by a panel of experts and clinicians in the field to indicate whether Metaphor and Psychoeducation videos were significantly different to each other, and to gather a range of perspectives around the preparation of the video.

At the debriefing stage, it is important to note that participants were unable to correctly identify which condition they were placed in. Whilst this was not a formal assessment of the video, it potentially indicates a lack of distinction between the two conditions. In order to assess metaphor efficacy, it was important that the two conditions were significantly different in terms of story-telling and metaphors. Reasons as to why the two conditions were not different may have been due to the same examples being used in both videos to demonstrate CBT concepts. Whilst these examples were not described as metaphors, they may have acted as stories to explain CBT concepts. As the examples were present in both conditions, this may indicate that the two videos were not significantly different from each other.

The example used in the videos was that of a young girl who did not want to go to school as she was scared of bullies. It can be argued that this example was easier to relate to than the metaphor used, which was that of a man being frightened of alligators. The desire to use metaphors that were described in literature may have led to more ambiguous stories than real life examples.

The limitations concerning the video may explain the final results, in that there were no differences found between Metaphor and Psychoeducation groups due to conditions being similar on key variables.

A potential confounding variable that may not have been accounted for is the participants' previous knowledge of CBT. Whilst care was taken to include participants who had not previously had any form of CBT, it was difficult to monitor reading material, as some individuals had been advised to read the "Overcoming" books as a self-help strategy whilst they were on

the waiting list. This may have affected their recall of the video, and their understanding of the content. In retrospect, this would have been helpful to assess prior to the delivery of the video.

Current thought and theory have advocated the utility of metaphors within a clinical population. However, there have been very little studies to test this. Studies that have looked at metaphorical understanding and memory with young people conclude that very young children struggle to comprehend metaphors. However, these studies have been riddled with methodological concerns. The current study is not exempt from the methodological issues identified. Coupled with this and the number of participants recruited to the study, it is impossible to properly evaluate the extent to which metaphors impact on memory and understanding.

Asides from memorability and comprehension, other benefits of metaphors may also be noted. Friedberg and Wilt (2010) claims that a key element of storytelling within clinical settings is the increase of engagement and fun that it fosters. This also may be particularly relevant for younger children.

The clinical implications of this study highlight the different linguistic tools that are used to present information to young people. Whilst it is not conclusive that metaphors have a positive impact on memory and understanding, there are indications that basic language may be harder for younger children to grasp. Therefore metaphors and stories may be useful to engage younger children in clinical content, and potentially increasing their memory and understanding.

The current study is the first experimental investigation within this field, and whilst some methodological errors have been noted, it is also important to recognise that this study opens the doors to further experimental research with metaphors. Metaphors can be hard to objectify and quantify, and thus experimental research has not been attempted in this field. The current study shows that this may be possible, and provides a protocol for others to adapt in the future.

Further research would be well received in this area, due to the lack of studies looking at metaphor use in therapy. As this is the first experimental study of its kind, an adapted methodological protocol could extend this novel research methodology, addressing the key concerns from the current study. Therefore, a greater number of participants, more standardised measures and thorough methodological preparation through video ratings and piloting, may lead to reliable conclusions.

Following on from the observations through correlations within the current study, further research could focus on the developmental aspect of metaphors to see whether there is a significant difference between older and younger children's processing and utility of metaphors within therapy.

Assessing the effect of metaphors on engagement may test out further hypotheses as to the utility of metaphors with young people. The current research opens up experimental testing of metaphors within a clinical setting.

In conclusion, whilst metaphors have been advocated through theory and case study, clinicians need to think carefully before using them, as overly obscure stories can end up being confusing and even unhelpful (Rose, 2003). There were some indications in the study that basic language is more accessible to older children than younger children, whereas concrete metaphors are equally as accessible to all. Due to the small sample size and methodological concerns, definitive conclusions cannot be made at this stage. However, painting a metaphorical picture may still be worth a thousand words.

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Executive Summary of Main Research Project

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Introduction

Metaphors are used in everyday language in the form of stories, analogy and imagery. It has been hypothesised that we use them to make concepts more understandable, and easier to remember. Metaphors use concrete examples to demonstrate abstract concepts and for this reason, metaphors are used heavily as a therapeutic tool to help people understand complicated ideas. This may be relevant for children and young people due to the increased accessibility of stories. Ideally metaphors should use examples from a young person's world, therefore making complex concepts seem familiar and easy to relate to. However, we do not know whether metaphors work as it has never been experimentally tested in different age groups.

In this study, we aim to see whether metaphors can increase an individual's understanding and memory for concepts. We also aim to see whether there is a difference between older and younger children.

Method

In order to test this, we recruited 25 children and young people on a waiting list to receive Cognitive Behaviour Therapy (CBT) for anxiety. We showed participants one of two videos – one had metaphors in and one used plain language. The videos consisted of psychoeducation about CBT, including what it is, and what the main concepts are. Main concepts addressed were around the role of avoidance in anxiety, and what happens when fears are faced.

Following delivery of the videos, participants answered questions about what they remembered from the video, and what they understood. Information about their level of avoidance and psychopathology was also taken at this time. Four weeks later, participants were invited back to the clinic to answer the same questions on memory and understanding. At this time, participants were also debriefed on the study and took away a copy of the two videos on DVD.

Results

Participants who watched the metaphor video were compared to those who did not. They were compared on variables such as memory and understanding for concepts explained in the videos, as well as their intention to change their behaviour. Results indicated that there were no differences between the two groups on each of these measures. This was also true at the four week time point. Analyses looking at the link between age and metaphor retention and understanding, demonstrated that there was no difference between older and younger children in their understanding of metaphors. However, there were significant results when looking at the group of participants that were exposed to plain language. This analysis stated that older children were more likely to understand and remember basic explanations than younger children. This potentially indicates that metaphors are a universal way of communicating complicated concepts to young people, and are accessible to all.

Limitations

There were some limitations to the current study that may have had an impact on the findings. The small participant number of 25 resulted in an underpowered study. Further research could build on the current study by recruiting more participants, and therefore carrying out further analyses. There were also methodological issues, as the video scripts were not rated by a panel of experts. Thus, it is difficult to conclude whether the two videos were significantly different to each other. Further research could build on this work by carrying out ratings.

Implications

Clinical implications for the research state that there is no difference between using a metaphor and using a basic explanation to describe concepts in therapy. However, caution needs to be made around using basic explanations, as they may only be accessible to older children. The abstract nature of using basic explanations may provide a barrier to younger children, thus making concrete metaphors a simple way of explaining information to younger children.

Research Connecting Narrative

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The Connecting Narrative refers to the Critical Review of Literature, the Service Improvement Project, the Main Research Project, and all Case Studies (C1 to C5). N.B the case studies are submitted as a separate portfolio.

Throughout the clinical training course I have been able to carry out a range of projects across different clinical populations, whilst learning the key aspects of research. Prior to training I had been lucky enough to work in a range of areas, but the variety of placements and projects that I have carried out has allowed me to explore these fields academically, as well as on a service level.

Within this narrative, I will reflect on each piece of work I have done across the lifespan, including the difficulties that I faced along the way, as well as what I learnt as a result of this.

Main research project

From the beginning of the course, a clear emphasis was placed on the main research project, and how this would be important to establish early on. The idea development phase was a crucial point, and multiple meetings with potential research supervisors were spent going through key literature and personal interest. From previous experience, I knew I wanted my main project to be with young people, but the area was unknown. Once an idea was generated, the methodology was loosely determined until a field supervisor was identified. My field supervisor (Dr. Shaun Brassington) worked in a local Child and Adolescent Mental Health Service and was able to identify a clear population group, and how my project was able to fit into the service. The ongoing support from a field supervisor has been a very important part in the development of the project. Whilst assisting in the identification and collection of potential participants, Shaun has also been able to provide supervision within the research process, which has been invaluable throughout.

The main project chosen was around the creative use of metaphors in therapy with young people. This topic was chosen following a discussion during research supervision with the Course Director, Professor Paul Salkovskis, who had previously authored a book in this field. The study tapped into an area that has been previously theorised, but heavily under researched. Finding this gap in the academic world was exciting, but this made the development of the methodology very difficult as nothing similar had been done before. A novel design was utilised, where I scripted,

filmed and edited a video that was used in the delivery of metaphors to young people.

The development of the script was done with the assistance of a Youth Participation Group. This is a collection of young people who were previously seen by CAMHS, and have opted in to raising awareness of mental health problems with children and young people, as well as representing young people on interview panels etc. They were able to provide me with very useful advice around the development of the script, with the wording used and how easy it was to follow.

This filming and editing of the video required the assistance of the University of Bath Audio Visuals team, who were able to provide a television studio, a range of equipment to film with, and expertise throughout the production of the video. Advertising for actors to be part of the film was part of this process, as well as directing actors during filming. Reflecting on the development of the video, this was a steep learning curve during the project development. I had little previous experience within media, TV and film. However, the process was fun and allowed me to build my skills repertoire.

Following the generation of the video, I had to take my proposal through an NHS ethics committee. The drafting of the lengthy application form, and production of the supporting documents allowed me to familiarise myself fully with the methodology of the project, and identify any problems in the plans. Unfortunately, as there was no teaching on the course to guide us through the process of NHS ethics, this was a time where I sought the support of my fellow trainees who were also going through the same process. We were able to share experiences and tips which have allowed me to understand what can be a very tricky process. Whilst gaining ethical approval was time-consuming and trying on occasions, I am glad to have taken part in this process. I am now familiar with the application form and the systems in place that are set up by the Research Ethics Committee, which will have an impact on my future involvement in research.

Once I received a favourable opinion from the NHS ethics committee, I was able to begin recruitment. I was met with genuine optimism by the service that I was working with, and so I was encouraged that I would be able to meet my recruitment target of 40. In the first 2 months of recruitment I was able to meet just under half of my target, but unfortunately after that, things did not go to plan. The service I was recruiting from lost many members of staff, therefore potential participants were not being identified for the study. I approached another service within the same Trust who agreed to recruit for me, but unfortunately did not find any appropriate participants. In the end, whilst I was not able to get together the desired number of 40 participants, I was still able to recruit 25 participants in total. This meant that I was able to carry out some analyses for my study. Unfortunately follow-up analyses were not able to be completed due to the high rate of attrition from the study.

In terms of recruitment, the most helpful process was having a positive relationship with the team. Some clinicians in the team worked hard to identify individuals that were suitable to take part in the study, and this formed a bulk of the final 25 participants. Thinking back, this would have been helpful to instigate earlier, rather than relying on just the waiting list in the early days of recruitment.

The process of research supervision during this project has been variable. The creative flair, vast research experience and expertise that was available to me was phenomenal, and made a huge difference in terms of the quality of the work that I produced, but also my learning around the research process. Unfortunately, things became difficult at times due to availability and accessibility of supervisor. This was resolved by outlining clear plans to deal with the lack of availability, such as booking in regular meetings every month or two in order to touch base and review key issues. I also realised quickly that emailing was not a good way of getting in touch with my research supervisor, and so I would rely on the regular face-to-face meetings to review written drafts as well as practical issues. On reflection, this was a very useful process to put in place, as without it I may have struggled to get appropriate supervision for this project.

The conclusions of the study were interesting but did not support the hypothesis that metaphors increase memory and understanding in children. The conclusion was surprising as metaphors have been used clinically in a range of disciplines for a number of years.

CAMHS case study

When working clinically with children, I was able to develop a creative set of metaphors to use with young people. An example of this was within my CAMHS case study, where I explored faddy eating with a 4 year old boy. Initially, I worked with the young boy to complete an assessment, and during this time it was helpful to use metaphors to explain the idea of therapy and why he was coming to see me. Further sessions were completed with parents to generate a collaborative formulation and put an intervention plan in place. This case study highlighted the importance of working through parents and other individuals, as this can have a massive impact on the child themselves.

Elective case study

Another case study where I similarly worked through a parent was during my elective year in a Community Paediatric setting. I worked with a mother to assess, formulate and intervene with her son's challenging behaviour, who was aged 5. Whilst this child did not have a recognised learning disability at this age, he had reported difficulties with his learning and was thought to have Autistic Spectrum Condition. A behavioural model was utilised, but throughout this process, it was identified that there were parental coping difficulties. This case study allowed me to put together and integrate complex formulations, ultimately benefiting the client as each issue was thought about from a range of perspectives.

Critical Literature Review

My interest in children with learning disabilities came from previous experience within Romanian institutions. The impact of attachment on difficulties in social functioning allows further understanding into the developmental role of relationships. Therefore I decided to explore the

research in this area for my critical literature review. Indiscriminate friendliness is a characteristic that has been identified in institutionalised children, however there has been debate over whether this is a symptom of disordered attachment, or whether it is a stand-alone construct. The process of completing a critical literature review was difficult, as I had little experience in this area. The teaching on this topic was carried out early on in our course, and focused on the more quantitative literature reviews, whereas I was hoping to do an evaluative review.

Through good university supervision and personal reading, I was able to synthesise the literature in the field of indiscriminate friendliness. As this piece of work required an intense amount of reading, it took longer than anticipated. However, the conclusions were interesting, and the final product achieved was satisfying to read. Conclusions of the literature review stated that indiscriminate friendliness was not a symptom of disordered attachment. This leads on to the question of how this characteristic evolves in children who have been institutionalised. One criticism of the literature review was that many of the studies did not screen for a learning disability. Indiscriminate friendliness has been seen in a range of different disorders associated with having a learning disability, for example Prada-Willi syndrome. When on my learning disability placement, I was able to see this in some adults with diagnosed genetic disorders.

Learning Disability case study

Whilst on my learning disability placement, I worked with a diverse range of difficulties and disorders, allowing me to adapt therapy for adults with a learning disability. My case study within this placement looked at how to adapt Cognitive Behaviour Therapy for Post-Traumatic Stress Disorder. This case allowed me to develop my creative skills, whilst adhering to treatment protocols for this difficulty. As much of the teaching on CBT therapy had been about working with adults of working age, it was useful to adapt this within learning disabilities.

Working Age Adult case study

The teaching in our first year was fantastic, often with well-established and respected clinical psychologists who had carried out an abundance of research within the area. As the course director's key interest was Obsessive Compulsive Disorder, it was helpful to consolidate knowledge through my first case study which was about applying Cognitive Behaviour Therapy for OCD. The ability to practice advanced skills learnt in teaching sessions was invaluable.

Older Adult case study

To build on work done in adult settings, the older adult placement allowed further consolidation of skills. My placement was split, with half of the work being therapeutic, and half of the work focusing around memory assessments for dementia. The case study I carried out on this placement was around adapting CBT for depression within this population.

Reflections around this included the multiple range of factors leading to the difficulties with depression. Systemic issues and risk management made following a treatment-driven protocol very difficult. Following our teaching on CBT for Self-esteem, in hind-sight it may have been helpful to focus on this aspect for the case study. Learning about the incorporation of complex risk management, whilst trying to carry out therapy was a useful learning point in this case.

Service Improvement Project (SIP)

As well as the therapeutic case study, I also wanted to explore the support given to carers of individuals being diagnosed with dementia, within the service. At the time of my placement, this support was delivered one-to-one with a Psychologist for approximately 4 sessions. The evidence base around working in this way is limited, and many services opt to carry out carers groups, to allow individuals to benefit from a supportive environment, and continue the support even after the group has finished in a sustainable fashion. Therefore, a Service Improvement Project was embarked upon at this placement around creating a protocol and piloting a carers group in collaboration with my supervisor, Dr Ben Newell.

The first process in setting up this project included writing a proposal and submitting this to the trust Research & Development Team. Following this, it was crucial to get the support of the team on side, as there had been some political issues over the past few years around carers groups that had started and then been decommissioned. It was important to clarify that this group was going to be psychological in nature, rather than just being informative. To do this, and to find out more information for the SIP, I consulted multi-disciplinary professionals within the team to find out what the needs were for clients and how they felt the group should go. Service users were also consulted, to find out what they had benefited from in the past, and what they felt would be useful. From discussions with psychologists in the team, a group protocol was developed.

Recruiting for the group was the hardest part of the project, as carers found it very difficult to come into the service to get support, due to difficulties around respite care for the care recipient. This was a common difficulty with the potential participants that were identified, and led to a group that only consisted of 3 individuals. Once the group had been run by a clinical psychologist (supervisor Dr. Ben Newell), I was able to carry out a focus group to find out views and opinions of what had been helpful, and what they would like to change. Carers reflected on how positive it was to have a small group, as it can be difficult disclosing sensitive information in a large group. Carers also talked about how the supportive environment made them want to return, as they were learning from each other and able to form relationships around shared experiences. This led to a reduced sense of feeling isolated.

Unfortunately, clinical outcome measures did not indicate that significant changes had been made throughout the group. A word of warning during the consultation with psychologists outlined that outcome measures may not fall during the group, as often individuals may become more aware of their difficulties.

A key part of the Service Improvement Project was feeding back the protocol and the results of the carers group to the psychology team, who

were thinking about implementing this in the future. Feeding back the protocol allowed an important discussion to happen around barriers to intervention for this population group, and how that could be overcome. Many ideas were generated, such as placing the group within a community setting rather than a clinic. Other ideas around the use of online resources allowed the team to think about how they were going to adapt the group format to access more individuals. The team were excited about the qualitative feedback from the carers, and made plans to implement the group in their respective bases.

Reflecting on this project, it was deflating to only carry out the study with a small number of carers. This was unavoidable, as my field supervisor was leaving the service, and had a small window of time to carry out the group. It was also difficult to discover that there were no significant differences in outcome. However, the point where I was able to realise that this had been a worthwhile project was when feeding back to the service. The recognition of recruitment difficulties, as well as potential outcome issues was reassuring. It was also very encouraging to note that the service was planning on continuing the group, thereby solidifying the “improvement” part of a service improvement project.

Final Case Study Reflections

Carrying out the varied range of case studies whilst being on placement has allowed me to develop my clinical skill set, whilst using this information to inform research ideas and interests. Whilst carrying out case studies, it was interesting to note that there were often limited gains on a range of validated outcome measures used to evaluate change. I often supplemented these outcome measures with subjective qualitative evaluations of therapy, as well as idiosyncratic outcome measures, such as a food diary. By doing this, I was able to pick up on changes that had not been reflected in validated outcome measures. Reasons for this may have been that the choice of validated measures were not varied and so did not pick up on the change of symptoms. However, this has also made me think about the use of outcome measures, and whether they are able to effectively pick up on change. As each individual is different, it is

important to reflect change based on a client's own personal goals, which outcome measures often fail to do. This has made me think about the services we work in, and how they are increasingly becoming reliant upon outcome measures. In terms of my future practice, it is important to continue using validated measures; however, there is also an argument for supplementing these with measures designed for the individual in order to pick up on nuanced change that is in line with client goals.

Final Research Reflections

An important reflection in terms of research is around my experience as a member of the first cohort of this training course. Research was emphasised as being a key part of the ethos to this course, and at times I feel the teaching has not reflected that. There were many lessons that were learnt through my peers on the course, rather than through the supervisors and teaching staff. An example of this would be the NHS ethics process, and the intricacies of carrying out a literature review. On reflection, it was an impossible task for the staff to pre-empt all the pit-falls of setting up a new course, and I am confident that the feedback we have given has had an impact on the future cohorts. Whilst this has felt frustrating at times, the level of accomplishment will be significant. I am confident that all pieces of work carried out during this course have made a significant contribution to the knowledge within their respective fields. Whilst being difficult at many points along the way, I have been able to overcome these and recognise the achievements at the end. I now feel confident to be able to take a study from idea development through to write-up, even though there may be complex factors to the study (such as a video and barriers to recruitment). All projects have been made possible by the individuals that have been able to support me throughout.

My experience during the course with regards to research has allowed me to consider how research can be done within a clinical environment. I hope to take up a clinical post that will allow me the opportunity to carry out service development as well as exploratory research. My choice to carry out research within a range of populations has set me up to feel comfortable to explore the literature in any service I may end up in.

Appendices

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CLINICAL PSYCHOLOGY REVIEW

AUTHOR INFORMATION PACK

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Elsevier accepts electronic supplementary material to support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, high-resolution images, background datasets, sound clips and more. Supplementary files supplied will be published online alongside the electronic version of your article in Elsevier Web products, including ScienceDirect: <http://www.sciencedirect.com>. In order to ensure that your submitted material is directly usable, please provide the data in one of our recommended file formats. Authors should submit the material in electronic format together with the article and supply a concise and descriptive caption for each file. For more detailed instructions please visit our artwork instruction pages at <http://www.elsevier.com/artworkinstructions>.

3D neuroimaging

You can enrich your online articles by providing 3D neuroimaging data in NIfTI format. This will be visualized for readers using the interactive viewer embedded within your article, and will enable them to: browse through available neuroimaging datasets; zoom, rotate and pan the 3D brain reconstruction; cut through the volume; change opacity and color mapping; switch between 3D and 2D projected views; and download the data. The viewer supports both single (.nii) and dual (.hdr and .img) NIfTI file formats. Recommended size of a single uncompressed dataset is 100 MB or less. Multiple datasets can be submitted. Each dataset will have to be zipped and uploaded to the online submission system via the '3D neuroimaging data' submission category. Please provide a short informative description for each dataset by filling in the 'Description' field when uploading a dataset. Note: all datasets will be available for downloading from the online article on ScienceDirect. If you have concerns about your data being downloadable, please provide a video instead. For more information see: <http://www.elsevier.com/3DNeuroimaging>.

Submission checklist

The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address
- Phone numbers

All necessary files have been uploaded, and contain:

- Keywords
- All figure captions
- All tables (including title, description, footnotes)

Further considerations

- Manuscript has been 'spell-checked' and 'grammar-checked'
- References are in the correct format for this journal
- All references mentioned in the Reference list are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Web)
- Colour figures are clearly marked as being intended for colour reproduction on the Web (free of charge) and in print, or to be reproduced in colour on the Web (free of charge) and in black-and-white in print
- If only colour on the Web is required, black-and-white versions of the figures are also supplied for printing purposes

For any further information please visit our customer support site at <http://support.elsevier.com>.

AFTER ACCEPTANCE

Use of the Digital Object Identifier

The Digital Object Identifier (DOI) may be used to cite and link to electronic documents. The DOI consists of a unique alpha-numeric character string which is assigned to a document by the publisher upon the initial electronic publication. The assigned DOI never changes. Therefore, it is an ideal medium for citing a document, particularly 'Articles in press' because they have not yet received their full bibliographic information. Example of a correctly given DOI (in URL format; here an article in the journal *Physics Letters B*):

<http://dx.doi.org/10.1016/j.physletb.2010.09.059>

When you use a DOI to create links to documents on the web, the DOIs are guaranteed never to change.

Online proof correction

Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.

If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.

We will do everything possible to get your article published quickly and accurately - please upload all of your corrections within 48 hours. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading

is solely your responsibility. Note that Elsevier may proceed with the publication of your article if no response is received.

AUTHOR INQUIRIES

For inquiries relating to the submission of articles (including electronic submission) please visit this journal's homepage. For detailed instructions on the preparation of electronic artwork, please visit <http://www.elsevier.com/artworkinstructions>. Contact details for questions arising after acceptance of an article, especially those relating to proofs, will be provided by the publisher. You can track accepted articles at <http://www.elsevier.com/trackarticle>. You can also check our Author FAQs at <http://www.elsevier.com/authorFAQ> and/or contact Customer Support via <http://support.elsevier.com>.

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Appendix B – Service Improvement
Project: University Ethics Approval

Department of
Psychology



UNIVERSITY OF
BATH

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Facsimile +44 (0)1225 386752
Email
psychology-enquiries@bath.ac.uk
www.bath.ac.uk/psychology

Dear Vaneeta

Reference Number 12-152

The ethics committee have considered your ethics proposal for the study entitled 'Piloting group based psychosocial interventions of dementia carers within an older adult CMHT' and have given it full ethical approval.

Best wishes with your research.

A handwritten signature in cursive script that reads 'H. Lucey'.

Helen Lucey
Chair of Psychology Ethics Committee

Appendix C – Service Improvement Project: R&D Trust Approval



Foundation Trust
For Gloucestershire **NHS**

Gloucestershire Research & Development Support Unit

Leadon House
Gloucestershire Royal Hospital
Great Western Road Gloucester
GL1 3NN

Telephone: 0300 4225463
Facsimile: 0300 4225469
Email: mark.walker@glos.nhs.uk

Tuesday, 25th June 2013

Vaneeta Sadhnani
Clinical Psychologist in Training
The University of Bath-6 West
Claveton Down
Bath
BA2 7AY.

Dear Vaneeta,

Study Title: Developmental factors in young people's ability to use metaphors
within therapy

REC Ref: 13/NI0082

R&D Ref: 13/015/2gt

I am writing to confirm the approval of 2gether NHS Trust for the above study to commence within the Trust. Your project will now be added to the Trust Research Register which will hold full details of your study, including:

- Title : **As Above**
- Chief Investigator/Project Lead: **As Above**
- Sponsoring Organisation: **University of Bath**
- Host Trust: **2gether NHS Foundation Trust**

It is important that all research conducted with NHS patients and/or staff now complies with the Research Governance Framework. In relation to this I would like to take the opportunity to remind you of some of your responsibilities under this framework.

- 1. Health and safety:** You are reminded of your responsibilities for health and

safety at work under the Health and Safety at Work Act 1974. You have a legal responsibility to take care of your own and other people's Health and Safety at work under the Health and Safety at Work ACT 1974 as amended and associated legislation. These include the duty to take reasonable care to avoid injury to yourself and to others by your work activities or omissions, and to co-operate with your employer in the discharge of its statutory duties. You must adhere strictly to the policies and procedures on health and safety.

2. **Codes of confidentiality/Data Protection:** Anybody who records patient information (whether on paper or by electronic means) has a responsibility to take care to ensure that the data recorded is accurate, timely and as complete as possible. It is vital that you conduct your research in accordance with the principles of the Data Protection Act 1998.
3. **Liability and Indemnity:** Indemnity for your study will be as described in any applicable Clinical Trial Agreement or other Research Contract.
Where such an agreement is not available, the Trust will indemnify its employees and researchers holding NHS Honorary Contracts for the purposes of Negligent Harm.
NHS Trusts cannot provide cover for No Fault or Non-Negligent claims. Where this is required, it is expected that the Research Sponsor will provide such indemnity.
4. **Intellectual Property:** Intellectual Property is defined as the tangible output of any intellectual activity that is new or previously undescribed. It can include the following:
 - i. Inventions, such as new medical devices, software;
 - ii. Literary works, such as software, patient leaflets, journal articles;
 - iii. Designs and drawings, such as posters, leaflets;
 - iv. Brand names, such as logos and trademarks; and
 - v. Trade secrets, such as surgical techniques.

For projects originating from outside of the NHS Trust with which this agreement is made, Intellectual Property rights will remain with the Lead Site/Investigator unless developed from observations made outside of the scope and influence of the project. The rights to Intellectual Property generated in such a fashion will remain with the Host Trust unless and agreement to the contrary has been signed by both parties.

5. **Adverse Events/Incidents:** Any adverse events you witness or suspect to have happened *must* be reported to your supervisor or manager as soon as you know about them.
6. **Fraud and Misconduct:** Any suspicions of active fraud or misconduct *must* be reported to your supervisor or manager immediately and will be treated in the strictest confidence. The monitoring of research will also seek to reduce incidents of research misconduct and fraud.
7. **Monitoring:** As part of the Research Governance Framework, during the course of your research you may be monitored to ensure that procedures in the protocol approved by the ethics committee are being adhered to.
8. **Dissemination:** The Framework also requires the dissemination of research findings to the research subjects, NHS staff and the public. On completion of your research you will be expected to produce a summary of the project and an indication of how the results from the study will be disseminated. You will receive a letter requesting this report from the Primary Care Research Governance Facilitator when you complete your research.
9. **Termination of Agreement:** The Trust also reserve the right to terminate the agreement for your research to proceed if, at any time, you are found to be in

breach of the clauses in this Approval Letter or fail to adequately meet the requirements of the Research Governance Framework.

I wish you every success with your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Mark Walker', written over a light grey rectangular background.

Mr. Mark Walker
Senior R&D Manager
Gloucestershire R&D Consortium

Clinical Psychology Forum – Frequently Asked Questions

What is Clinical Psychology Forum?

Clinical Psychology Forum (CPF) is the official monthly publication of the Division of Clinical Psychology of the British Psychological Society. As well as reflecting the diverse and individual views of the Division's membership, CPF also publishes regular updates about DCP policy and business in order to inform its membership. Further information is provided in the Guidelines for Contributors.

What are the aims of Clinical Psychology Forum?

Its aims are to provide a platform for the publication of members' views, opinions and comments around the profession of clinical psychology within the UK and to update the membership via the dissemination of articles and commissioned pieces reflecting current and future good practice within clinical psychology.

What type of articles do you consider for publication?

CPF welcomes contributions which are original, innovative, authoritative and of interest to the membership of the Division. We aim to publish a variety of contributions ranging from personal reflections on clinical practice, critiques of current health policy, innovations in service development and audit and research studies. For guidance on successful publication has been published by the Editorial Collective - see editorial published in CPF 227, October 2011, page 9 or the Editorial Advice document on <http://www.bps.org.uk/networks-and-communities/member-networks/division-clinical-psychology/contributions>.

What types of articles do you tend not to publish?

We frequently reject audits and service evaluations that are based on small samples, have poor methodology and perhaps lack standardised measures or statistical analysis, and produce findings that are only relevant to the clinical context in which they were conducted. Similarly, trainee's academic course work or individual clinical case studies work will only be published if it is highly original and relevant to the general readership of the journal.

It is also important that authors can speak authoritatively from a position informed either by their own experience or from a well-informed scholarly

perspective. This is particularly important for reviews that advocate principles of good clinical practice.

Personal reflective pieces are accepted but again, authors should assure themselves and the Editorial Collective that the article will be of interest to the wider readership and Division members. Personal observations might be more suited to the correspondence pages rather than as a full article?

How do I know whether my article is suitable?

We are unable to give general advice about the suitability of individual manuscripts: that is the main purpose and function of the review process. If you believe that your manuscript is particularly unusual and falls outside of the guidance above, please feel free to approach the editor for advice; although in the majority of cases this will mean that it will just go out for review.

Who can submit articles to Clinical Psychology Forum?

We will consider submissions from anyone who has written an article that meets the above guidance. Primarily, we would expect to receive submissions from within the UK, since the focus of the publication is the practice of clinical psychology within the UK.

It is important that all authors indicate their job title and role. Non-psychologists, psychology assistants, trainees and graduate workers are welcome to submit articles. Where the focus of an article is a clinical service within which the assistant, trainee or graduate worker are working, we would expect their supervisor to have had sight of the submitted article and a footnote to this effect should be included in the article.

May I also submit my article for consideration in other publications?

We do not encourage dual publication and there may be serious copyright considerations if this were to happen. Please notify us, at the time of submission if you have previously or currently submitted your article to any other publications, as we would not wish to simultaneously review or publish a paper.

However, we do not usually impose restrictions on your published article being printed in other publications but would request that acknowledgement to CPF be included. Indeed, there may be a case for some very pertinent or useful papers being published both within CPF and other Society publications.

Do you have a letters page?

We publish correspondence either about articles published within CPF or on issues of general interest to the membership. We may seek a reply to the letter and if possible will publish it alongside the original

correspondence. We may edit the length of your letter, especially if it exceeds 200 words. The decision of the coordinating Editor is final.

What guidance on style do you offer?

Please follow the Society's Editorial Style Guide -

<http://www.bps.org.uk/publications/policy-and-guidelines/general-guidelines-policy-documents/general-guidelines-policy#styleguide>

Please also follow the CPF Guidelines for Contributors -

<http://www.bps.org.uk/networks-and-communities/member-networks/division-clinical-psychology/contributions>

What format should I use when submitting an article?

We request that articles be compiled using double line spacing, in a reasonably sized, easily readable font (minimum 11pt, maximum 14pt) and that all pages are numbered.

Do you offer guidance on the terminology to use?

Contributors are asked to use language which is respectful and psychologically descriptive rather than medical, and to avoid using devaluing terminology (i.e. avoid clustering terminology like 'the elderly' or medical jargon like 'schizophrenics').

In addition, language should conform to the Society's guidelines on non-sexist or discriminatory terminology.

We acknowledge that language is context specific and that occasionally authors may wish to justify the use of particular terms commonly adopted within specific contexts. Please include any such qualifications within an accompanying footnote.

Is ethical approval required?

We would obviously wish to know that any studies which are published were conducted ethically and, where appropriate, that ethics approval has been sought. In the case of experimental or research papers, we would expect acknowledgement usually of an NHS Local Ethics Committee or a University Ethics Committee.

Where approval has not been sought, the authors should account for the lack of ethical scrutiny and what steps were taken to ensure that the research was ethically conducted.

Should I include an abstract?

We request that all articles include a summary, maximum 40 words, at the beginning of the paper.

Do I need to include references?

We request that articles include an accurate list of all references cited at the end of the paper. Please follow the Society's Editorial Style Guide when compiling this. Please only cite essential references.

How long does CPF like papers to be?

We request that articles have a minimum of 1000 words and a maximum of 2500 words (including references, affiliations, word count, etc.). Please ensure that the total word count is included at the end of your article.

May I incorporate tables and figures?

Tables and figures may be included in your article, but only if they enhance it. Note that the CPF is a black and white publication, so please make sure that your tables and figures still make sense when printed in black and white.

May I include my questionnaire?

We ask readers to request a copy of any questionnaires directly from the contact author, rather than include it in the article itself.

May I use acronyms in my article?

We do accept the use of acronyms, but please spell them out the first time they appear.

What contact details do you require?

We request that articles include the names of all authors, together with their affiliations and job titles. Please ensure that the full postal address of the contact author is given for correspondence. We normally like to publish an email address where readers might contact the authors individually.

Additional contact details - email, telephone, mobile - would be advantageous. Indeed, an email address is almost essential since reviewers will probably want to contact you that way. If you have provided a postal address and it is a home address or address that you wish to remain confidential, please can you ensure that this is clearly indicated on your manuscript.

How do I submit my article to the CPF?

Please email one copy of your completed article in Word format to Sue Maskrey (s.j.maskrey@sheffield.ac.uk) and post one copy to her at:

Sue Maskrey, CPF Administrator, Clinical Psychology Unit, University of Sheffield, Sheffield S10 2TN.

What happens when I submit an article?

When your article is received, it will be logged and given a unique identity number. Each month, all articles registered will be submitted to the Coordinating Editor for allocation to a member of the Editorial Collective. Each article is then distributed to the reviewer, with a requested turnaround of eight weeks. The contact author will be notified of the allocated reviewer and also the deadline.

Depending on the view of the reviewer, the article may be accepted, accepted with minor modifications, accepted with extensive modifications or rejected. We reserve the right to shorten, amend and hold back copy, if needed.

How long does the whole process take?

Timescales vary considerably but on average the whole process, from submission to publication, takes approximately nine months to a year.

Occasionally, articles may be accepted or rejected with minimal delay. More frequently, however, there is liaison between reviewer and contact author.

Delays may be incurred where protracted dialogue is necessary or where communication is hindered (e.g. annual leave or illness). Delays have sometimes been experienced due to unnotified changes of the contact author's employer or contact details.

Final publication also depends on the authors returning a completed copyright form.

What happens to my paper after submission?

Further information on what happens after submission is published in the Annual Report 2011 and is reproduced below (comparable figures for the previous year are in parenthesis).

The Journal is in a healthy state with 103 (110) submissions from December 2010 to November 2011. Of these, 33 (41) were accepted for publication, 73 (61) are awaiting revision, or are still under review (including some that were submitted in the previous year) and 14 (6) were rejected. All rejected articles now receive two independent reviews; the majority provided by the Coordinating Editor. These figures reflect previous years whereby the Editorial Collective has been more selective leading to

more rejections and a greater number of articles left in the queue for revision and resubmission.

We have revised our Guidelines for Contributors and FAQs published on the CPF website to include the most recent editorial advice. We also have a large number of articles under revision and we are currently writing to all these authors to see whether they still intend to resubmit their papers. The review process is still relatively rapid, taking about a month for allocation to a reviewer, two months for the review, and up to six months waiting for publication.

The average time taken from Submission to Allocation is five weeks, based on records between December 2010 and November 2011 inclusive. Allocations are done on a monthly basis as indicated and, this year, 45 per cent were allocated within a month compared to 50 per cent last year. Papers awaiting allocation for between 9 and 12 weeks have dropped from 13 per cent last year to 3 per cent this year. These occasional delays are due to re-allocations where reviewers have a conflict of interest or may not be available to review due to illness or annual leave.

The average time taken from Allocation to Review is one-and-a-half months, and 74 per cent have been reviewed within two months compared to 69 per cent last year. The average time taken from Review to Acceptance is two months, which is comparable to last year. The average time taken from Acceptance to Copyright Requested is one week, with 70 per cent dealt with in a week compared to 72 per cent last year. The average time taken from Copyright Received to Publication is four months, which is the same as last year. However, speed of publication has increased with only four per cent taking over six months.

What happens if I am asked to resubmit?

If you are asked to resubmit an amended version of your article please ensure that you return the amended version, showing tracked changes, directly to the original reviewer and state in an accompanying letter how you have addressed their concerns. This should also be copied to Sue Maskrey, the Administrator. The reviewer will then contact you again to inform you whether your resubmitted version is suitable for publication and will copy Sue Maskrey into the decision letter. Where possible all correspondence should be submitted by email but we would recommend that you retain a hard copy.

What happens if the reviewer is unsure whether to accept or reject my article?

This situation only rarely occurs but the procedure is that the reviewer will request a second opinion from another member of the editorial collective or the Coordinating Editor. The contact author is notified of the situation and of the secondary reviewer. The final decision is then communicated by the original reviewer to the author(s).

What are my options if my article is rejected?

Should your article be rejected by the reviewer you will be notified of the reasons directly. Should you disagree with the justification offered you should initially contact the reviewer to discuss. If, after discussion, an amicable conclusion is not reached, you may contact the Coordinating Editor for a final decision. You may also wish to consider submitting your article for consideration to an alternative publication.

What if I want to complain about Clinical Psychology Forum?

If you feel that you have been unfairly treated by the editorial process offered through Clinical Psychology Forum or wish to take issue with the journal's published content, please contact the Coordinating Editor in the first place. If this is inappropriate or if your complaint has not been satisfactorily dealt with, we suggest that you contact either the Director of the Membership Services Unit or the DCP Chair.

What happens once my article is accepted?

The reviewer will notify you or the administrator. The administrator will then confirm acceptance in writing and request that you complete and return the copyright form submitted. You will also be asked to email an electronic copy of the final, accepted article.

On receipt of both the signed copyright form and e-copy, your article will await publication in the next appropriate edition. There is usually a wait of between three and six months before publication. Articles are published in the order that they are finally approved for publication on receipt of the copyright form. The decision of the Coordinating Editor is final.

You will be notified of pending publication and you will receive a complimentary copy of the edition incorporating your article. If, in exceptional circumstances, your article remains unpublished beyond six months after acceptance, please notify the administrator.

Do you publish special issues?

From time to time CPF will commission or receive special issues on a particular theme that should be of interest to a large proportion of the readership. These usually take up to a year to organise and will have around eight articles put together by one or two commissioning editors.

A member of the CPF Editorial Collective will be allocated to the special issue and assist in the final editing of the papers and ensuring that they are suitable for publication. Occasionally we have to turn down ideas for special issues to preserve space for publishing ordinary articles.

If you are interested in compiling a special issue, please contact the Coordinating Editor with an outline, rationale and names of potential

contributors. Following discussion within the collective, we will get back to you and let you know whether you should proceed.

How do I become a member of the Editorial Collective?

From time to time we will review the membership of the Collective and invite new people to join. Should you wish to be considered for membership of the Editorial Collective, you may request a copy of the statement of interest form by contacting the administrator.

On receipt of your completed form, the Coordinating Editor will be notified and your application will be considered at the next six-monthly meeting of the editorial collective. The usual term of office for the editor or members of the collective is three years, but a second term is considered for appropriate members and preserve within the collective a suitable balance of expertise and experience.

Appendix E – Service Improvement Project: Clustered codes

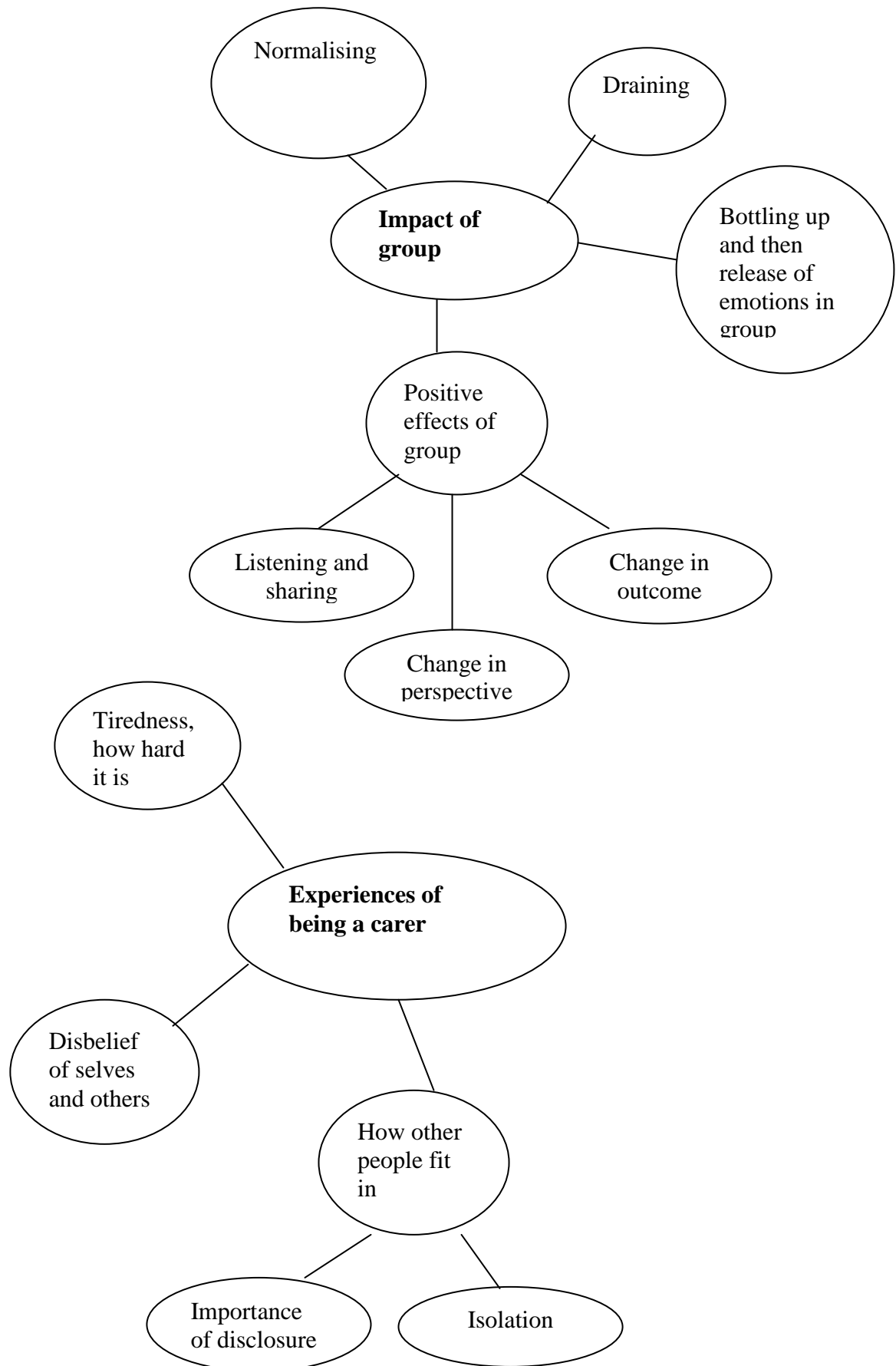
Experiences associated with being a carer
<i>The strain of caring</i>
It's just that at the end of the day it gets very tiring.
Every day now, for the last nearly a month, every day, not just once but 4 times in an hour "Do I have to mow the church", and then I say "no" and then it's "why" "how do you know" and I have to go through the whole thing, what I said. But it doesn't go in, does it(....)But the thing is, it's very hard
So I think evenings are the worst for me, and late afternoons perhaps, Cos in the day you're sort of busy aren't you, well trying to be.
then sometimes you are so weary you don't feel you want to make the effort to do, you know, its enough to cope with
But I don't shout at him, so I just keep explaining explaining.
But I think he can tell by the tone of my voice (laughs) that I'm getting tired. And I just say "I did tell you" and he'll say something else and I'll say "I did tell you"
I mean some people are that much younger dealing with it, but when you just get that little bit older (2 laughs) it's a strain (both laugh)
cos you do get tired don't you, I get terribly tired.
So I get up and I check all the phones , just to give him peace of mind
But they say the same thing over and over again.
<i>Disbelief</i>
This is what I find hard, somebody that just loved a cup of tea
But I just can't believe that somebody who was so good at figures, so good at his job, is like he is.
You can't believe it, you know, he asks me how to spell little words and I just think, gosh you used to be my dictionary
It was as if, he froze, I could see the look of disbelief in his face, someone that's worked with engines and fuel all his life
...and it's things like that when it comes through that anything that the children and everything they've always asked dad about things to do with (fuels?) and that is what no-one can just get to grips with really.
Our middle daughter, I said she still can't believe it cos she says to him, if Tony says something she'll say "are you having me on Dad?, are you joking?" and he says "no I can't remember" she says "but we only talked about it 10 minutes ago" (laughs) I don't think she can really quite believe
2: They can't believe he's like he is...
<i>Feeling alone</i>
And also I found myself not telling anyone for a long time, and it was getting noticeable
You sort of shut yourself off a little bit.
The isolation is there
Sometimes I feel like you know, can he help me do anything at all, cos he forgets, you know he goes back 30 or 40 years in his mind very often
Yeah you can't speak quite as freely in front of the person you're looking after can you(....) its like a bit of a fantasy world sometimes you sort of go into,
Yeah cos I do think, you know my friends say "how's (X)" and I say "oh he's fine" you know, you don't want to feel like saying, "well he's really like this" well they'll get fed up won't they, they don't want to know

Impact of group
<i>Changes following group</i>
There were things like when they were explained a different way to, I felt quite interested that I hadn't picked up on. Things that (facilitator) sort of said to us, goals and things to set.
and it was nice, because (facilitator) did convey us some ideas to make us think another way, didn't he
I was looking through some of the paperwork this morning and I was reading through and I thought "yes some of it's quite interesting the paperwork we had"
Um it did help me a little bit on a few things. Because I used to get very embarrassed when we were in the supermarket (....) and I said "Oh I keep thinking people think oh that older man there being so silly". But he (group facilitator) said do you think they really are, or are they busy getting on with their lives really and it's in your head that they're saying that. And I said well, so I have to turn it around that way(.....)he recognised 2 ladies on the checkout that he always teases, and I sort of walked away and went on doing the shopping and I could hear them laughing and I thought "They're not offended by him"(....) but there wasn't any annoyance or anything and I thought no that's ok, cos he was just laughing and joking
Like contact people that I hadn't, you sort of shut yourself off a little bit. I contacted different people that I hadn't contacted for a long time.
But (facilitator) said that keep telling them, because some of the people that have got dementia, think that part of it does go in. So that's another thing that I've picked up on, so I do try and answer it every time.
Yeah, it did help me a little bit with, well the last session we had, as regards my appointment with the consultant. You know I was worried about how I was going to be able to tell him anything that was happening now(.....)I suddenly thought "wow he was right (facilitator)" he said something will happen, you'll start something and then something will happen that will help you and it did.
So I think it was admitting a little bit that something had changed and then they just fell into place those things.

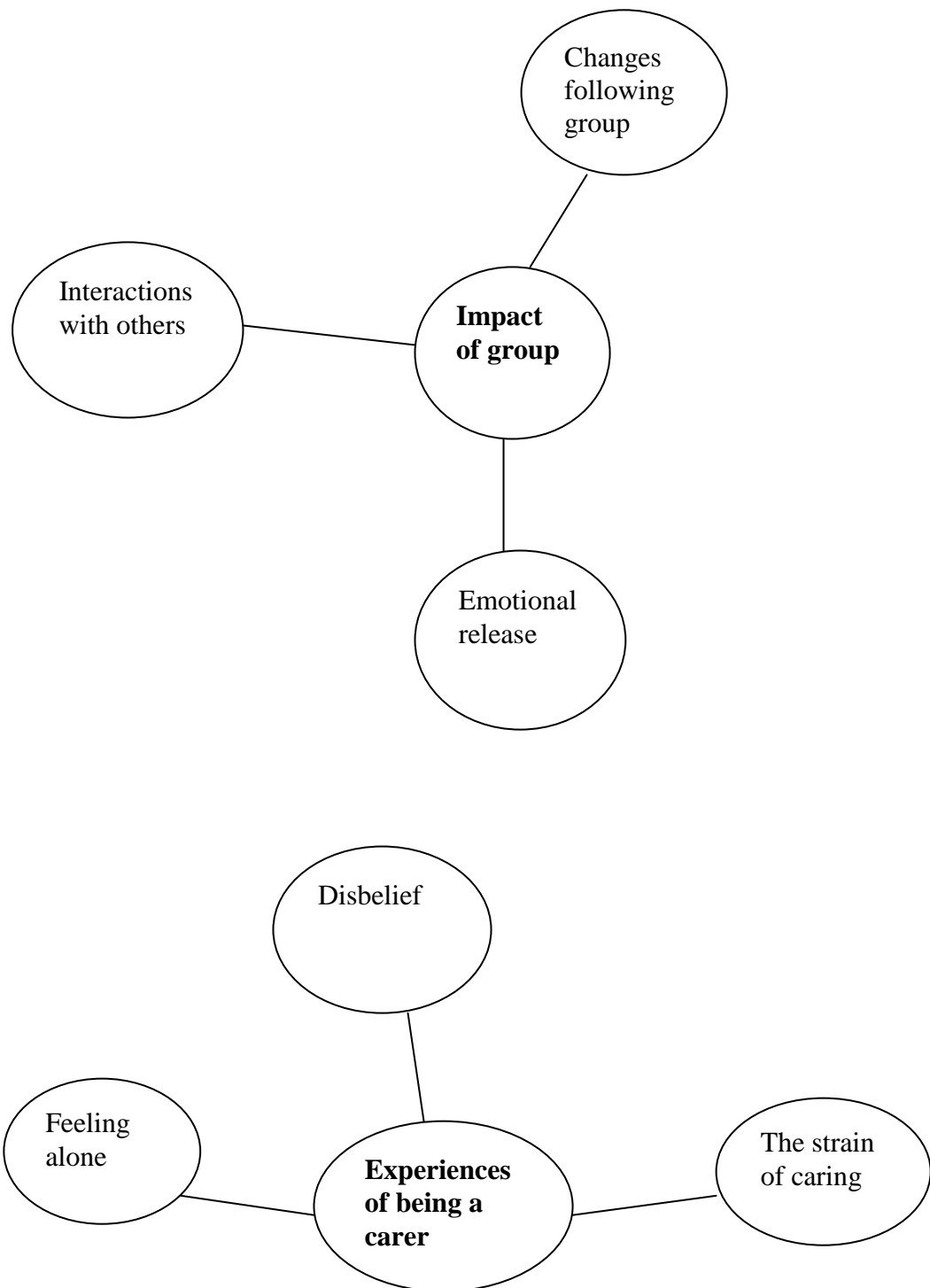
<i>Interactions with others</i>
Well it was very interesting. It was nice to hear, and listen to everyone and what was happening
(re best thing about the group) Listening to eachother, and exchanging experiences about what's happening.
I do really enjoy the, well just listening to everybody else.
I feel quite pleasant now being here. Listening, and chatting.
you know things that happen, and you thought "ooh I recognise that", that trait.
That's exactly what's happening in our house
...but sometimes the interaction it helps. Like with the cups of tea, look straight away I knew what you were thinking because it was happening to us.
It makes you realise that that trend is with the dementia, not the person.
Bit comforting to think, it's just something he's doing that I'm picking up on.
It means you don't think to yourself "am I going mad myself", there's that feeling sometimes.
It did certainly help to know there were other people with the same type of things going on, albeit different temperaments whatever. But the same sort of things, having to deal with, so it was quite nice to know

<i>Emotional release</i>
1: Yeah it was quite draining, did you find that?
2: Yeah, I felt shattered when I got home
I think when you got home, and you sort of had to rearrange your brain a little bit. It was in your head for a long time
except for the tiredness, later on I think I felt drained.
um, it was nice to be able to sometimes burst everything out that's inside you that you want to say and you can't say to family sometimes,
and you are sort of bringing out all your emotions, you're bringing out your worries.
yeah. It was sort of a release of the feelings you get inside
But it's quite nice isn't it to release something, that's how I felt,

Appendix F – Service Improvement Project:
Thematic map 1



Appendix G – Service Improvement Project:
Thematic map 2



Appendix H – Main Research Project: Script for video

What will we hear	What will we see
<p>Tess: Hello and welcome to our video explaining CBT for anxiety. Anxiety means worry or when you get really stressed. My name is Tess and this is Ian. You might have heard these 3 letters a lot – C, B and T, but what does it mean to you?</p> <p>Well, they refer to a kind of therapy called Cognitive Behavioural Therapy</p> <p>Emma: What is Cognitive Behavioural Therapy, that doesn't make any sense to me</p> <p>Tess: Well, it's about what we think ...</p> <p>affecting how we feel</p> <p>and this affecting what we do.</p>	<p>Tess, Ian and Emma standing in shot. Tess speaking straight to camera.</p> <p>Pointing to camera.</p> <p>Emma looks confused Close up of just Emma</p> <p>Camera pans out to include everyone in shot. Table and cake appear in the corner. Everyone looks at the table and cake, and then look at eachother.</p> <p>Tess faces camera and carries on talking, whilst Emma sneaks off from the group toward the table.</p> <p>Picture of thought bubble next to Emma with cake saying "That cake looks yummy"</p> <p>Tess in shot</p> <p>Close up of Emma smiling and licking her lips</p> <p>Tess in shot</p> <p>Close up of Emma eating the cake and putting it all into her mouth</p> <p>Tess and Ian looking at eachother and shaking their head.</p>

overcome our worries.

Emma: Yeh, I haven't been to school in a week! Mum is going mad at me – but I have decided that I do not want to go to school again. It is awful.

(Only in Metaphor condition)

Ian: Well, I wanted to tell you a story about my neighbour, Arthur. We never used to see Arthur, he would stay in his house the whole time and only come outside to take the bins out. One day when he was taking the bins out, I thought I would introduce myself, you know, be the nice young lad from across the road, see if he was ok. So I asked him why he never used to come out, and he said he was really frightened of alligators!

Emma and Tess: "Alligators!?"

(Looking at each other)

Ian: I know that's what I said! I told him there ain't no alligators around here, don't be silly". And Arthur said, "well, it might happen! And then you'd be sorry!" And with that he went back inside and shut his door.

Emma: What?! That's so silly. Arthur is avoiding all the good things about coming outside just because he thinks there might be alligators outside?

Tess: Yeah – it's a bit like avoiding all the good things about school just because you think there might be bullies there.

(Only in Psychoeducation condition)

Ian: Well, as we mentioned before, we don't want to put ourselves in scary situations – I mean who would want to do that? It's really obvious that you might want to avoid doing something that is scary. But what we know is that

Emma signalling finality with her hands. Crossing both hands over each other.

Talking to Emma

some people avoid doing things so much that they become more scared!

If we think about why we are scared of something in the first place, it might be because something bad has happened to us. But it might be because we are scared of what we *think* might happen. We don't know what will happen, but the fear of what might happen often stops us from doing lots of things. What do you think might happen if we stop doing all the things we are frightened of Emma?

Emma: Well, I suppose we'd never do anything would we, and plus we'd miss out on all the good things because we were frightened of what might happen!

Tess: Yeah – it's a bit like avoiding all the good things about school just because you think there might be bullies there.

Emma: Oh. Are we talking about me now?! Well I didn't see that one coming....I suppose I am avoiding school because of all the bad potential things that might happen....hmmmm.

Well, actually, I lied before, I have been to school this week. It's just when I went, I wore a really big hat so no-one could see my face. And that worked actually. No-one bullied me!! I think wearing that hat is the key to being safe.

Tess: Oh ok. So you started doing something to make yourself feel safer? Lots of people do that to give themselves a sense of security. But these things don't make them realise that they can deal with the situation just as it is!

(Only in Metaphor Condition)

Ian: So I want to tell you about

Emma getting a bit annoyed.

Pause here and looks at the others

Pulls a big hat onto face

Arthur again – after I spoke to Arthur, he actually started coming out of the house every so often, which was great! But then I noticed he was putting salt at the end of our road every day. He would sprinkle it very carefully and then go back inside his house. One day, I asked Arthur, “why are you sprinkling salt at the end of our road?”, and he told me “well, it’s to stop the alligators from coming to this street”. I said “Oh no, not alligators again!? There ain’t no alligators around here, don’t be silly”. And Arthur said, “well....that’s how I know the salt is working!”

Emma: Ohh so Arthur was doing something to make himself feel safer – but if he just stopped sprinkling the salt, he might realise there are no alligators!! Well, not in this country anyway!

(Only in Psychoed condition)

Emma: What do you mean?

Tess: Well, when something scary happens, we want to keep safe don’t we. Lots of people might do things that they *think* keep them safe, but actually don’t do anything at all! What might happen though, is that we become so attached to this behaviour we do to keep safe, that we forget things would be quite the same if we stopped doing the behaviour. In fact, if we stopped doing the thing we think will keep us safe, we might realise what we are scared of is in fact not that bad!

Emma: Ohh, so when we are scared of things, we might try doing extra things to keep us safe. But actually these things might just get in the way of us realising that what we’re scared of is actually not that scary?

Ian: Spot on, so maybe not wearing your hat to school might make you

realise that school isn't so scary?	
Emma: oh. School talk again!? But, honestly, I don't think I could do it, I think I would go completely mad.	
Tess: Ah that's interesting. So if you went to school, with no hat, how scared would you get?	
Emma: Really really really scared!!	
Tess: If you had to draw it on this thermometer for me...	Tess draws thermometer on the screen
Emma: It would be about here....	Emma indicates way over boiling point on the thermometer
Tess: wow, that looks pretty bad. You don't want to get up there do you? So if you're not up there right now, what happens every day?	
Emma: Well if I think about homework it goes up	Picture of thermometer in the corner of the screen going up and down when Emma says up and down
but then I make myself stop thinking about it and it goes down for a little while	Thought bubble coming out of Emma's head with someone doing homework
but then it goes up again every morning when I need to go to school	Thought bubble bursting and other things replacing the thought bubble
and then I either avoid going and it goes down again, or mum says I have to go and it goes up again!	Image of someone getting ready for school
And then I wear my hat so it goes down again.....	Image of argument between mum and daughter
oh I don't know, it just goes up and down, up and down!	Picture of a massive hat
	Image of thermometer getting bigger and coming into the middle of the

screen going up and down and up
and down and then exploding

(Only in Metaphor condition)

*Tess: Wow, it sounds like your fear
of school is a bit like a
rollercoaster!*

Emma: I love roller coasters!!

*Tess: But what you are doing is
you are coming off the rollercoaster
just at the scariest bit! If you stayed
on the rollercoaster a little bit
longer, your anxiety would go
up...and up and up. But it will stop
going up eventually, because roller
coasters must come down. Once it
hits its peak, then it will fall back
down, and that's what your anxiety
does! When it comes down, that's
the best bit! It will feel amazing the
first time you ride that roller
coaster, but the more you do it, the
less scared you'll feel (because
you've already done it). Your fear is
just like a roller coaster – what
goes up must come down!*

*Emma: oh wow. I didn't know that.
So anxiety is a bit like a
rollercoaster.*

*Tess: Yeh, and the more you ride
it, the less scary it will be*

(Only in Psychoed condition)

*Tess: Wow, that sounds like it's
changing all the time, but not
getting any better?*

*Emma: Yeh, it just goes up and
down all the time, and I don't know
what to do about it.*

*Tess: Well sometimes people find if
they don't do things that will make
their anxiety go down (for example,
wearing a hat, or make yourself
stop thinking about it), then actually
your anxiety would go higher.*

Emma: well obviously!

Tess: Wait, I'm not finished yet!
Your anxiety will go up a bit, but
actually after a while it will plateau.
And then guess what it does
(Emma shrugs shoulders "goes up
a bit more?") – your anxiety
actually goes down all by itself!
Your anxiety cannot carry on going
up forever, it must come back
down. And your body does this
when it realises that it can cope
with what you are scared of.
Can you guess what happens the
next time you want to do the thing
you are most scared of?

Emma: surely the same thing will
happen

Tess: Yes, but this time your
anxiety won't go as high. So your
body will realise that you can cope
with this situation a lot quicker than
last time.

Emma: Oh my goodness, that must
mean the more I do it the better it
gets??

Tess: exactly – the more you
practice this, the better it gets!

Emma: That's weird actually, it
sounds scary but it sounds like
something I could do – I'd only do it
with help though!

Ian: That's the best bit – CBT is
about working with you, and
experimenting to see what works
best for you.

Tess: So folks – there's a quick
introduction on what those 3 little
letters stand for – C, B, and T!

Pointing at the others when she says
"I'll only do it with help"

Camera pans to Ian talking to
camera.
Pointing at the camera when saying
"what works best for you"

Tess speaking to camera
C, B and T coming up on the screen
one by one, in red letters. Like



<p>It's about:</p> <ul style="list-style-type: none"> - How your thoughts link to your feelings and then make you do (or not do) some things - We can sometimes avoid things that are scary. But avoiding things will stop us from overcoming our fears. - We can try new things to make us feel safe, but these might not help us realise that the thing we are scared of, is not actually that scary at all! - Trying to do things differently might be really scary at first, but actually your anxiety will not rise forever! It will come back down eventually, and the more you do it the less scary it'll be!! <p>We hope this has given you a good introduction to CBT. Now we would like to ask you some questions about this video.</p> <p>Good luck and Take care</p>	<p>On a white screen, bullet points coming up. First point - "thoughts, feelings, behaviours" written up. Image of CBT cycle next to writing</p> <p>2nd bullet point "Avoiding things will stop us from overcoming our fears"</p> <p>3rd point – "Things we do to keep us safe might not help us"</p> <p>4th point – Your anxiety goes up when you do things you are scared of, but it will come back down all by itself.</p> <p>Screen back to Tess talking to camera.</p> <p>Camera pans out to Ian, Tess and Emma waving good bye.</p>
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Scoring manual

Memory

Levels of memory

- Avoiding what you are scared of is bad, or doing things you are scared of is good (2 points)
 - o Using the example of Emma avoiding school or Arthur not going outside (1 point)
 - o 1 extra point if remember why Emma avoided school (bullies) or why Arthur didn't go outside (alligators)
- Safety seeking behaviours are used, but are not helpful long term (2 points)
 - o Using the example of Emma's hat or Arthur's salt (1 point)
- When you are exposed to something you are scared of, anxiety will go up, but eventually it will plateau and come back down all by itself (anxiety is like a rollercoaster example) (2 points) (1 extra point if identifying that Emma's anxiety goes up and down up and down, before getting on the roller coaster)
- Knowing what CBT stands for (1 point)
- Thoughts → Feelings → Behaviours cycle (2 points) (variations on this with only 2 elements, 1 point)

Maximum points → 13 points

Understanding

- 1) Rob was talking about the Cognitive Behavioural cycle. Can you remember what that was?
 - a) Feelings affecting thoughts (1 point)
 - b) Thoughts affecting behaviour (1 point)
 - c) Feelings affecting behaviour (1 point)
 - d) Thoughts → feelings → behaviour (2 points)
- 2) What kinds of people get thoughts in their head that make them feel worried or sad?
 - a) Everyone/anyone (1 point)

- 3) Can you give any reasons why someone might avoid what they are scared of?
- a) 1 point for each valid reason (i.e. because it causes them anxiety, people don't want to feel scared if they don't have to, they can do other things that make them feel better, they think something bad will happen to them)
- 4) What is good about avoiding things you are scared of?
- a) 1 point for each valid reason (i.e. you don't have to feel scared) – must give reference to the feelings you can avoid.
- 5) What is unhelpful about avoiding things you are scared of?
- a) It might make you feel more scared (1 point)
 - b) You never learn to face your fears (1 point)
 - c) You miss out on fun things (1 point)
 - d) You never learn that your fears are actually not that bad (2 points)
- 6) People sometimes do things to make themselves feel safer. What does that do and why?
- a) Makes them feel safer (0 points)
 - b) It is helpful and makes the person feel better (-1 points)
 - c) It helps the person at the time (1 point)
 - d) It is helpful for some time but then it gets worse again (2 points)
- 7) What happens to anxiety when you stay in a situation that makes you feel scared for a long time?
- a) It will go up and up (1 point)
 - b) It'll continue getting worse forever (-1 points)
 - c) It will go up, but then it will reach a point and come down on its own (2 points)
- 8) If you want to overcome your fears, how should you go about doing that?
- a) Expose yourself to your fears (1 point)
 - b) Keep persisting with it so that you overcome your fear (1 point)
 - c) Drop your safety seeking behaviour (1 point)

- 9) Sophie is scared spiders. She hates going to her bedroom because she saw a spider under the bed once. What should Sophie do to stop being frightened of spiders?
- a) Talk to her parents (0 points)
 - b) Stay in bed tolerating the anxiety (1 point)
 - c) Exposing self to spider (1 point)
 - d) Think about nice things (0 points)

Appendix J – Main Research Project: Specific Questions post video

Thank you for watching the video.

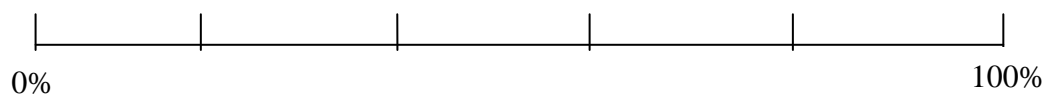
- 1) Can you tell me everything you remember about what Tess, Emma and Ian said in the video. Try and remember as much detail as you can, and use the same wording as you can.

Understanding

- 1) Tess was talking about the Cognitive Behavioural cycle. Can you remember what that was?
- 2) What kinds of people get thoughts in their head that make them feel worried or sad?
- 3) Can you give any reasons why someone might avoid what they are scared of?
- 4) What is good about avoiding things you are scared of?
- 5) What is unhelpful about avoiding things you are scared of?
- 6) People sometimes do things to make themselves feel safer. What does that do and why?
- 7) What happens to anxiety when you stay in a situation that makes you feel scared for a long time?
- 8) If you want to overcome your fears, how should you go about doing that?
- 9) Sophie is scared spiders. She hates going to her bedroom because she saw a spider under the bed once. What should Sophie do to stop being frightened of spiders?

Intention to change

How much does this video make you want to do things differently when you feel anxious?



- What would you like to do differently?

-
-
-

The video makes me want to avoid the thing I am scared of:

- More ☐
- Less ☐
- The same ☐

CCBAS

Children's Cognitive Behavioural Avoidance Scale

Instructions: Different people use different strategies to deal with situations and problems in their lives. Below are a number of strategies that people may use to deal with situations and problems. A number of the items below refer to dealing with situations at work or school. If you are not currently working or attending school, answer these items instead using your daily duties and activities. Please read each statement carefully and indicate how true, *in general*, each statement is for you using the following key:

- 1= **Not at all** true for me
2= **Somewhat** true for me
3= **Moderately** true for me
4= **Very much** true for me
5= **Extremely** true for me

1. I avoid attending social activities.	1	2	3	4	5
2. When I am not sure about my future, I do not sit down and think about what I really want.	1	2	3	4	5
3. I would like to achieve things at work/school, but I have to accept my limits.	1	2	3	4	5
4. I do not do what is needed to achieve goals I have set for myself.	1	2	3	4	5
5. In order to avoid feelings of disappointment, I just try not to get too serious about school.	1	2	3	4	5
6. Rather than try new activities, I tend to stick with the things I know.	1	2	3	4	5
7. I choose to turn down opportunities that will help me further my education/career.	1	2	3	4	5
8. I do not answer the phone in case people are calling with social invitations.	1	2	3	4	5
9. I quit activities that challenge me too much.	1	2	3	4	5
10. I try not to think about problems in my personal relationships.	1	2	3	4	5
11. I think to myself that I will not be able to complete really challenging tasks.	1	2	3	4	5
12. While I know I should make decisions about my personal relationships, I just let things go on as they are.	1	2	3	4	5
13. I avoid trying new activities that might lead to failure.	1	2	3	4	5
14. I do not go out to events when I know there will be a lot of people I do not know.	1	2	3	4	5
15. Instead of thinking about problems in my social life, I tell myself that I prefer to be alone.	1	2	3	4	5
16. I fail to discuss/address tension and problems that builds in a friendship.	1	2	3	4	5
17. I find that I often want to leave social gatherings.	1	2	3	4	5

18. I avoid thinking about ways to improve my school performance.	1	2	3	4	5
19. I try not to think about my future and what I will do with my life.	1	2	3	4	5
20. I just wait out tension in my relationships hoping that it will go away.	1	2	3	4	5
21. I tend to make up excuses to get out of social activities.	1	2	3	4	5
22. There is nothing I can do to improve problems in my relationships.	1	2	3	4	5
23. I turn down opportunities to socialize with the opposite sex.	1	2	3	4	5
24. I tend to keep to myself during social gatherings or activities.	1	2	3	4	5
25. I avoid making decisions about my future.	1	2	3	4	5
26. When I am confused about my relationships, I do not try to figure things out.	1	2	3	4	5
27. While I know that I have to make some important decisions about school, I do not do it.	1	2	3	4	5
28. Rather than getting out and doing things, I just sit at home and watch TV.	1	2	3	4	5
29. I distract myself when I start to think about my school performance.	1	2	3	4	5
30. I do not bother thinking about how to solve problems in my family – it is useless.	1	2	3	4	5
31. I find myself avoiding tasks and assignments that are really important.	1	2	3	4	5

Appendix L – Main Research Project:
NHS Ethical Approval 1



**Office for Research Ethics Committees
Northern Ireland
(ORECNI)**

HSC REC 3

17 June 2013

Miss Vaneeta Sadhnani
Trainee Clinical Psychologist
Taunton and Somerset NHS Trust
University of Bath
Claverton Down
Bath
BA2 7AY

Customer Care & Performance Directorate

Office Suite 3
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Lisburn
Co. Antrim BT28 1TW
Tel: + 44 (0) 28 9260 3107
Fax: + 44 (0) 28 9260 3619
www.orecni.hscni.net

Dear Miss Sadhnani

Study title: Developmental factors in young people's ability to use metaphors within therapy
REC reference: 13/NI/0082
IRAS project ID: 125719

Thank you for your email dated 12 June 2013 and further email clarification received 14 June, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Ms Jan Daley, jan.daley@hscni.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **favourable ethical opinion** for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

1. *In the Under 10 PIS there is reference to CBT. Please spell this out and give a simple definition.*

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Ms V Sadhnani	23 May 2013
Evidence of insurance or indemnity	Professional Indemnity; Employer's Liability	11 July 2012
Investigator CV	Ms V Sadhnani 1.0	23 May 2013
Investigator CV	P Salkovskis 1.0	23 May 2013
Letter from Sponsor	Prof Jane Millar	08 May 2013
Letter of invitation to participant	Initial opt out 1.0	23 May 2013
Letter of invitation to participant	Participants 1.0	23 May 2013
Other: Email, Ms V Sadhnani		29 May 2013
Other: Video script	1.0	23 May 2013
Participant Consent Form	2.0 (Children & Young People)	12 June 2013
Participant Consent Form	2.0 (Parents)	12 June 2013
Participant Information Sheet: Parent	1.0	23 May 2013

Participant Information Sheet	2.0 (Young People)	12 June 2013
Participant Information Sheet	2.0 (Children Under 10)	12 June 2013
Protocol	1.0	23 May 2013
Questionnaire: CCBAS	1.0	23 May 2013
Questionnaire: Memory and understanding outcome measure	1.0	23 May 2013
REC application		24 May 2013
Referees or other scientific critique report	Kate Rimes	29 October 2012
Response to Request for Further Information	Email addressing response to provisional opinion	12 June 2013
Summary/Synopsis	Layman's summary 1.0	23 May 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

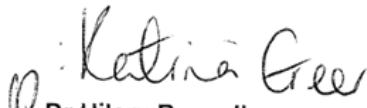
Further information is available at National Research Ethics Service website > After Review

13/NI/0082	Please quote this number on all correspondence
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely


Dr Hilary Russell
Chair

Email: jan.daley@hscni.net

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Prof Jane Miller*
Pro-Vice Chancellor Research
The University of bath
Claverton Down
BATH
BA2 7AY

Mr Mark Walker
2gether NHS Foundation Trust
Gloucestershire R & D Office
Leadon House
Gloucestershire Royal Hospital
Great Western Road
Gloucester
GL1 3NN

Appendix M – Main Research Project: R & D Approval



Foundation Trust
For Gloucestershire **NHS**

% Gloucestershire Research & Development Support Unit

Leadon House
Gloucestershire Royal Hospital
Great Western Road
Gloucester
GL1 3NN

Telephone: 0300 4225463
Facsimile: 0300 4225469
Email: mark.walker@glos.nhs.uk

Tuesday, June 25, 2013

Vaneeta Sadhnani
Clinical Psychologist in Training
The University of Bath-6 West
Claveton Down
Bath
BA2 7AY.

Dear Vaneeta,

Study Title: Developmental factors in young people's ability to use metaphors within therapy

REC Ref: 13/NI0082

R&D Ref: 13/015/2gt

I am writing to confirm the approval of 2gether NHS Trust for the above study to commence within the Trust. Your project will now be added to the Trust Research Register which will hold full details of your study, including:

- Title : **As Above**
- Chief Investigator/Project Lead: **As Above**
- Sponsoring Organisation: **University of Bath**
- Host Trust: **2gether NHS Foundation Trust**

It is important that all research conducted with NHS patients and/or staff now complies with the Research Governance Framework. In relation to this I would like to take the opportunity to remind you of some of your responsibilities under this framework.

1. **Health and safety:** You are reminded of your responsibilities for health and safety at work under the Health and Safety at Work Act 1974. You have a legal responsibility to take care of your own and other people's Health and Safety at work under the Health and Safety at Work ACT 1974 as amended and associated legislation. These include the duty to take reasonable care to avoid injury to yourself and to others by your work activities or omissions, and to co-operate with your employer in the discharge of its statutory duties. You must adhere strictly to the policies and procedures on health and safety.
2. **Codes of confidentiality/Data Protection:** Anybody who records patient information (whether on paper or by electronic means) has a responsibility to take care to ensure that the data recorded is accurate, timely and as complete as possible. It is vital that you conduct your research in accordance with the principles of the Data Protection Act 1998.
3. **Liability and Indemnity:** Indemnity for your study will be as described in any applicable Clinical Trial Agreement or other Research Contract. Where such an agreement is not available, the Trust will indemnify its employees and researchers holding NHS Honorary Contracts for the purposes of Negligent Harm. NHS Trusts cannot provide cover for No Fault or Non-Negligent claims. Where this is required, it is expected that the Research Sponsor will provide such indemnity.

4. **Intellectual Property:** Intellectual Property is defined as the tangible output of any intellectual activity that is new or previously undescribed. It can include the following:

- i. Inventions, such as new medical devices, software;
- ii. Literary works, such as software, patient leaflets, journal articles;
- iii. Designs and drawings, such as posters, leaflets;
- iv. Brand names, such as logos and trademarks; and
- v. Trade secrets, such as surgical techniques.

For projects originating from outside of the NHS Trust with which this agreement is made, Intellectual Property rights will remain with the Lead Site/Investigator unless developed from observations made outside of the scope and influence of the project. The rights to Intellectual Property generated in such a fashion will remain with the Host Trust unless an agreement to the contrary has been signed by both parties.

5. **Adverse Events/Incidents:** Any adverse events you witness or suspect to have happened *must* be reported to your supervisor or manager as soon as you know about them.

6. **Fraud and Misconduct:** Any suspicions of active fraud or misconduct *must* be reported to your supervisor or manager immediately and will be treated in the strictest confidence. The monitoring of research will also seek to reduce incidents of research misconduct and fraud.

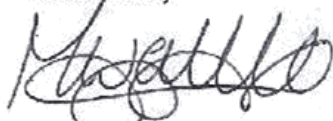
7. **Monitoring:** As part of the Research Governance Framework, during the course of your research you may be monitored to ensure that procedures in the protocol approved by the ethics committee are being adhered to.

8. **Dissemination:** The Framework also requires the dissemination of research findings to the research subjects, NHS staff and the public. On completion of your research you will be expected to produce a summary of the project and an indication of how the results from the study will be disseminated. You will receive a letter requesting this report from the Primary Care Research Governance Facilitator when you complete your research.

9. **Termination of Agreement:** The Trust also reserve the right to terminate the agreement for your research to proceed if, at any time, you are found to be in breach of the clauses in this Approval Letter or fail to adequately meet the requirements of the Research Governance Framework.

I wish you every success with your project.

Yours sincerely



Mr. Mark Walker
Senior R&D Manager
Gloucestershire R&D Consortium

Cc: Dr. Shaun Brassington_2gether NHS Foundation Trust

Behavioural and Cognitive Psychotherapy

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Submissions will be sent out for review exactly as submitted. Authors who want a blind review should indicate this at the point of submission of their article, omitting details of authorship and other identifying information from the main manuscript but including a separate title page. Submission for blind review is encouraged.

Abbreviations where used must be standard. The Systeme International

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- Tharp, R.G. and Wetzel, R.J. (1969). *Behaviour Modification in the natural environment*, New York: Academic Press.
- Roskies, E. and Lazarus, R.S. (1980). Coping theory and the teaching of coping skills. In P.O. Davidson and S.M. Davidson (Eds), *Behavioural medicine: changing health lifestyles*. New York: Brunner/Mazel.

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8. *Figure captions*. Numbered captions should be typed on a separate page.

9. *Figures*. Original drawings or prints must be submitted for each line or half-tone illustration.

10. *Required Sections*

Acknowledgements

You may acknowledge individuals or organisations that provided advice, support (non-financial). Formal financial support and funding should be listed in the following section.

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Behavioural and Cognitive Psychotherapy is an international

multidisciplinary journal for the publication of original research, of an experimental or clinical nature, that contributes to the theory, practice and evaluation of behaviour therapy. As such, the scope of the journal is very broad and articles relevant to most areas of human behaviour and human experience, which would be of interest to members of the helping and teaching professions, will be considered for publication.

As an applied science, the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes.

While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the journal from time to time publishes case studies using single case experimental designs. For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Other types of case report can be submitted for the Brief Clinical Reports section.

The following types of articles are suitable for *Behavioural and Cognitive Psychotherapy*:

- Reports of original research employing experimental or correlational methods and using within or between subject designs.
- Review or discussion articles that are based on empirical data and that have important new theoretical, conceptual or applied implications.
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The accelerated publication section is intended to accommodate a small number of important papers. Such papers will include major new findings for which rapid dissemination would be of considerable benefit and impact. For example: reports of the results of important new clinical trials; innovative experimental results with major implications for theory or practice; other work of unusually high calibre.

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(Revised 17th March 2013)